IN THE CHANCERY COURT OF JACKSON COUNTY, MISSISSIPPI

MIKE MOORE, ATTORNEY GENERAL, ex rel,
STATE OF MISSISSIPPI TOBACCO LITIGATION

NO. 94-1429

DEPOSITION OF WILLIAM LUCKETT

Deposition Taken at the Instance of
the Tobacco Defendants
In the Offices of the Phelps, Dunbar
Jackson, Mississippi
On May 22, 1997
Commencing at 9:30 a.m.

REPORTED BY: CHERIE G. BOND
Registered Merit Reporter
CSR #1012

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REPRESENTING THE TOBACCO DEFENDANTS

ALSO PRESENT: Pam Ellis

MR. YOUNG: I'd like to go ahead and premark his disclosure statement, CV -- first the notice, disclosure statement. Then I sent a letter yesterday --

MS. SCHWARTZ: Right. I want a statement on the record about the letter.

MR. YOUNG: Right. That's fine. So if you'll premark all three of those for me, please.

MS. SCHWARTZ: And are we agreeing that usual stipulations, only objections to form are necessary?

MR. YOUNG: Yeah, that's fine, by the case management order.

MS. SCHWARTZ: Okay.

(Exhibit 1, 2 and 3 marked)

MS. SCHWARTZ: I'm going to go ahead and put a statement on the record. I received yesterday a letter from Mr. Young to John Hay of my office in which Mr. Young states that he intends to refrain from asking Mr. Luckett certain unidentified areas of testimony that he anticipates Mr. Luckett will testify about on the grounds that these unidentified areas are covered by a motion in limine in this case.

I just want to state for the record that

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Mr. Young foregoes asking any questions of Mr. Luckett at his own choice, at his own risk, that we're not agreeing that any -- whatever these unidentified areas that Mr. Young anticipates Mr. Luckett will testify are not covered by any pending or granted motions in limine in this case.

MR. YOUNG: Our position is stated in the letter that has been attached as Exhibit 3.

MS. SCHWARTZ: You've marked this?

MR. YOUNG: Yeah.

MS. SCHWARTZ: Okay.

MR. YOUNG: Could I get you also to premark this as Exhibit 4 before we get started.

(Exhibit 4 marked)

WILLIAM LUCKETT,

having first been duly sworn, testified as follows:

EXAMINATION

BY MR. YOUNG:

Q Good morning, Mr. Luckett. I introduced myself before we got started today. I'm Lee Young, and I'm here on behalf of the State of Mississippi. Have you ever sat for a deposition before?

A No.

Q Okay. I'm sure Ms. Schwartz has gone over with you sort of the guidelines for a deposition and

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what's going to happen, but let me just go over a couple of them with you. The first and foremost, to help her out, is the fact that you've got to give a verbal answer to our questions. It's easy to -- when we're sitting here talking, to give a nod of the head or something of that nature. So you need to make sure you give a verbal response.

A I will.

Q If at any time you don't understand the question that I ask or that I misstate something or make it improper, please let me know and I'll try to restate the question.

A I will.

Q So we're both on the -- I want to make sure we're both on the same page before you provide an answer. Okay?

A That's -- I will do that.

Q If you could, please state your full name for the record.

A My name is William S. Luckett.

Q And your current address?

A My address is [DELETED]

Q And that's in [DELETED]

A That's correct.

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Q Okay. Is that your business address or your home residence?

A That's my home residence.

Q Do you have a business address?

A No, I don't. I'm semiretired, and I don't have an office.

Q So any work you do, then, would be out of your home.

A Right.

Q All right. If you could, please look for me real quick at what's been marked as Exhibit 1. That's the notice of your deposition today. Do you recall having seen that?

A I haven't seen it.

Q Okay. Could you take a moment to review it, please, for me.

A Okay.

Q If you'll recall in the notice of deposition, it requires you to produce certain documents and items that you've either reviewed in the case and correspondence with counsel and things of that nature. To the best of your knowledge, have you complied with that in terms of producing everything?

A I have.

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Q Okay. You mentioned a second ago and I may have misunderstood you. Did you say semiretired?

A That's true.

Q And when you say "semiretired," you're retired from your occupation at Peat Marwick I understand. Is that correct?

A That's correct.

Q But when you -- the semi part is because you do consulting work?

A I still do consulting work, and I work -- I'm a part-time employee of Jeff Anderson Regional Medical Center in Meridian. I work at Jeff Anderson two days a week on a regular basis.

Q Jeff Anderson --

A Regional Medical Center.

Q -- Regional Medical Center. And that's where, I'm sorry?

A In Meridian.

Q Meridian. Okay. And what is your position there?

A I'm a -- my official title is assistant to the president. I serve as more of a financial sounding board in administration of the hospital.

Q Financial sounding board?

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A That's what I would, I guess, group my expertise in insofar as my service to Anderson Hospital.
Q Okay. Could you sort of elaborate on that a little bit for me in terms of what you -- what you consider to be a financial sounding board?
A Well, I'm involved in negotiating managed care contracts for the hospital. I advise them on financial matters such as investments. I advise them on Medicare and Medicaid reimbursement issues. I advise them on proposed expansions of services at the hospital, this type of projects.
Q All right. So they do treat Medicaid recipients at Jeff Anderson Regional Medical Center?
A They do.
Q Okay. Do they receive DSH payments?
A No, they don't.
Q They are not a DSH hospital?
A No, they are not.
Q Okay. Do they treat indigents?
A Yes, they do.
Q Okay. Are you under contract with the Jeff Anderson?
A I do have a contract as a part-time employee of Jeff Anderson Hospital. This is

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strictly an employment contract.
Q I understand. There in Meridian, do you know are they a private hospital?
A They are a not-for-profit 501(c)(3) hospital.
Q Not for profit?
A (Deponent nodded head.)
Q Meaning?
A They are not subject to income taxes and they have to comply with the 503 -- I'm not sure whether it's 501(c)(3) statutes of the IRS.
Q Are they the main hospital in Meridian?
A They have three acute care hospitals in Meridian.
Q And they are one of them?
A Right.
Q Okay. Are they county-owned?
A No, they are not. It's not a county-owned hospital in Meridian, Mississippi.
Q Okay. Who owns Jeff Anderson Regional?
A Technically, it has no ownership. It's a not-for-profit hospital with -- the community, in the end, would be the owner of that hospital.
Q The community is?
A That would be my definition.

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Q Taxpayer-owned hospital?
A Well, it's not owned by the city or county, but it's just a private not-for-profit 501(c)(3) hospital, not unlike Baptist Hospital or St. Dominic's hospital.
Q Okay. This contract, your employment contract with Jeff Anderson, does it require you to disclose your work with -- in this case?
A They know that I'm -- I am here, but it doesn't require any disclosure of that.
Q Okay. All right. Other than that, that's the semi part of your -- when you say "semiretired"?
A I do other consulting work as well on a limited basis.
Q Okay. We'll come back to that in a second. If you can, tell me -- if you can just sum up your educational background for me, please.
A I graduated from Mississippi State with a B.S. degree with a major in accounting in 1961.
Q Have you had any training past --
A Oh, I've had other training.
Q -- formal education?
A No other formal education. I went to work with Arthur Anderson after graduating from college and left Arthur Anderson in November of 1961 and

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joined Peat Marwick here in Jackson and remained there until I took early retirement effective June 30th, 1992. There were, obviously, training programs and seminars that was a part of that training program with that firm.
Q Okay. How long were you with Arthur Anderson?
A I forget the exact starting date, but I started with Peat Marwick on November 13th, 1961. I was with Anderson probably from July to the first week in November.
Q What was your reason for leaving?
A Well, I was born and raised about 35 miles north of here, and I went to Atlanta because I wanted to join, at that time, one of the big eight accounting firms. I had -- Peat Marwick was the only big eight accounting firm in Jackson at that time. I had a brother-in-law who was working with Peat Marwick here at that time; and when he quit, I came back to Jackson.
Q All right. And your positions with Peat Marwick, if you could tell me a little bit --
A Well, from the entry level, accountant. I was promoted to the partnership effective July 1, 1973.

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Q Did you have a special area within Peat Marwick?

A In the -- probably beginning in 1970, my emphasis was in health care. I developed a health care practice in Peat Marwick and maintained that practice until I took retirement.

There were other entities that I worked on simply because most of the hospitals or the majority of the hospitals in the State have a September 30th year end, and with the workload being concentrated in that year end there were other entities that I worked in. Insurance was one of the areas. I have worked on a life insurance company or two, property and casualty and a medical insurance company.

Q Okay. You said you developed a health care practice within Peat Marwick along in about -- I guess you developed it up until you became partner in '73, and then that's where you spent the majority of your time until you retired?

MS. SCHWARTZ: Objection.

A That's true. I did develop a health care practice with Peat Marwick. I guess the first health care client that I worked on was in the late '60s, and developed some expertise in hospital financial matters and began gaining clients and --

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up until I retired.

BY MR. YOUNG:

Q Okay. Let me ask you -- when you say you developed a health care practice within Peat Marwick, what actually did you do in terms of that health care practice within that? If you can generally describe that for me.

A Well, as Medicare and Medicaid became more important to hospitals, they sensed a need for better accounting records and more expertise in that area, and I had developed the expertise in my own self to be of assistance to those hospitals.

Q In terms of what? Doing what for them?

A Well, we -- it was -- the work that we did for those health care clients was a combination of things. Primarily it was the audit of those financial statements. In conjunction with the audit, we would assist in preparation of the various cost reports required by the various programs and to ensure that they have got the proper reimbursement for services that they provided to cost reimbursement programs.

Q Okay.

A There were other consultant services that the firm did supply, make available. I wasn't

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necessarily involved in some of those services such as information services, computer-related systems work. We would bring in expertise from offices that hires those services.

Q Were you actually involved in auditing these hospitals?

A I sure was.

Q Okay. How many -- how many years do you think you were involved in that?

A Oh, probably 25.

Q Twenty-five years?

A Right.

Q Okay. How many hospitals -- if you could like -- if you could put a number on it, an estimate of numbers of the number of hospitals that you have audited in the State of Mississippi, I'm assuming?

A That's correct.

Q Okay. Within the State of Mississippi?

A This is purely a guess, but we -- I have probably been involved in auditing, from a financial point of view, 35 to 40 at one time or another. Sometimes you lose clients and sometimes you gain clients.

Q Thirty-five to 40 hospitals?

A Right.

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Q But you would do more than one audit of these hospitals. Is that right?

A Oh, it would be one audit each year.

Q Okay. So you may have done several audits?

A Oh, there would be hundreds of audits.

Q Okay.

A I thought your question was the number of hospitals.

Q You're listening very carefully because that's what my question was. So within -- for any of these 35 to 40 hospitals, you would have done an audit per year for these depending on the, like you said, losing or gaining a client from year to year?

A That's right.

Q And that would have spanned from maybe 1973 up until your retirement?

A That would have started before 1973.

Q Okay. Were any of these hospitals county or state-owned hospitals?

A Some of them were county-owned hospitals.

Q Any state-owned hospitals?

A I haven't done an audit on a state-owned -- a financial audit on a state-owned hospital.

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Q Can you give me an example of a state-owned hospital that you know of?
A I would consider University Hospital being a state-owned hospital.
Q UMMC?
A Right.
Q Okay. You said from a financial auditing standpoint. What other kind of audits have you been involved in besides financial audits?
A We were a contractor in the earlier years going back to late 1960s through -- and I can't tell you the exact date when it ended, but we were a subcontractor with Blue Cross in auditing the Medicare cost reports for these hospitals.
Q Medicare or Medicaid?
A Medicare.
Q Okay. What did that involve?
A That was -- each year a hospital submits a cost report claiming reimbursement for services rendered to Medicare beneficiaries. We would be assigned a hospital by Blue Cross. They would give us a limited -- in some cases a limited audit program to verify the accuracy of the areas that they wanted reviewed.
Q Did you do these for any -- is there a

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similar report for Medicaid?
A It's a joint -- comparable in most cases for Medicare and Medicaid. It's the same form with different settlement schedules within that form for Medicaid.
Q Did you do any for Medicaid or did you have to look at both at the same time?
A We were contracted to audit the Medicare aspect of it. It's my general understanding that the Medicaid program utilized the results of the audit done for Medicare to determine their reimbursement.
Q Well, did the hospital want to get reimbursed for its Medicaid payments?
A Yes.
Q Okay. And how would they do that?
A They would file this joint cost report that would have their cost included in that report, and it would be a separate set of -- separate set of summons schedules that would include the Medicaid activity.
Q Okay. And it would be based upon the work you did for the -- on the Medicare settlement schedule?
MS. SCHWARTZ: Objection.

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A I'm sorry. Rephrase the question.
BY MR. YOUNG:
Q Would the Medicaid settlement schedule be based upon the work that you did in terms of the Medicare reimbursement schedule?
A Medicaid utilized the same cost report for determining Medicaid's share of the cost as Medicare did.
Q The hospital would also use that, wouldn't they, in terms of getting reimbursed for their Medicaid payments?
A That's right.
Q The report that you helped prepare. Isn't that right?
MS. SCHWARTZ: Objection.
A The hospital submitted a joint Medicare/Medicaid cost report.
BY MR. YOUNG:
Q That wasn't my question, so maybe I need to rephrase it. The joint -- did you help prepare the joint cost report?
A In some cases I did.
Q Okay. Now, give me some times when you remember preparing a joint cost report for hospitals.

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A Most of the hospitals that we performed a financial audit on, we assembled or prepared a cost report that the hospital submitted to the Medicare and Medicaid intermediaries.
Q Can you give me some examples of when you recall doing this?
A We would do that in a normal course of auditing the financial statements of the hospital because that was an integral part of the revenue stream of the hospital. We would have to determine, within reason, what we thought the reimbursement of Medicare and Medicaid should be in order to opine on the financial statements of the hospital.
Q And this went on for how long? How long did you do this?
A I started doing that before the Medicaid reimbursement system became law. We started this back in the late 1960s. This went on until I retired.
Q So if I was looking for one of those reports, could you give me the title?
A It would be a Medicare/Medicaid cost report for any hospital that we may have audited where we prepared those.
Q Did you do any for UMMC?

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A I can't recall exactly. I did do some -- small amount of work out there in the -- maybe in the early '70s or something like that, but I can't even tell you exactly. I think that was more of a consultant arrangement that I had with them. I didn't actually prepare the cost report itself is my recollection.
Q Okay. Well, what do you recall doing for UMMC in the early 1970s?
A Consulting with them on preparation of the Medicare cost report.
Q Medicare/Medicaid cost report?
A I believe that was after the Medicaid program became reimbursable based on costs.
Q So the answer would be yes?
MS. SCHWARTZ: Objection.
A I believe that to be right.
BY MR. YOUNG:
Q Did you work with them as a consultant in your capacity with your employment with Peat Marwick?
A That's right.
Q What about Singing River Hospital in Pascagoula?
A I have done some work for Singing River

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Hospital.
Q Have you prepared or helped prepare joint cost reports for Singing River Hospital?
A I don't believe that I've ever prepared a cost report for them. I have reviewed their cost report. That cost report was prepared in-house. It would be -- we would have to review that cost report to determine whether we thought it was reasonable or not in conjunction with our financial audit of Singing River Hospital.
Q How long has Singing River Hospital been one of your clients or a client of Peat Marwick, I should say?
A This is purely a guess. I probably started doing some work down there in the middle '80s.
Q Up until your retirement?
A Right.
Q How about Forrest General Hospital?
A I haven't done any work for Forrest General as it relates to the cost reports.
Q Are they a client of Peat Marwick?
A Not a financial audit client. I'm not aware of anything that Peat Marwick is doing for Forrest General right now.

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Q Okay. Other than your financial -- you talked about financial auditing work and then you talked about working with Blue Cross/Blue Shield in a subcontractor capacity to help prepare auditing reports or cost reports for certain hospitals. What else besides that did you do?
A For who?
Q For the hospitals.
A We would be involved in some situations where they -- we would do a financial feasibility study in connection with bond issues and this type of thing.
Q You mentioned earlier that you also, during your work, had done some work for insurance. Life insurance?
A Right.
Q What did that entail?
A A financial audit of a life insurance company.
Q How about the medical insurance?
A A financial audit of a medical insurance company.
Q Okay. Did you ever do any work for the Department of Finance Administration?
A Not that I recall.

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Q Okay. What about with the Mississippi Comprehensive Health Plan?
A Not that I recall.
Q During your tenure with Peat Marwick, okay, did you work in any capacity, whatsoever, consulting or doing actual work for any division or the State of Mississippi?
MS. SCHWARTZ: Objection.
A Yes. Peat Marwick audited the public employees retirement plan for a couple of years. I can't remember the years or how many years, but we have audited -- Peat Marwick did audit the public employees retirement plan. Outside of that, I don't recall any.
BY MR. YOUNG:
Q Did you participate in that audit?
A I did.
Q What year was that probably, to the best of your knowledge?
A Mid to late '80s.
Q Do you remember who you worked with or what agency you worked with with regard to -- which state agency you worked with in connection with this audit?
A As I recall, there was a contract with the

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Public Employees Retirement System itself.
Q Do you remember the personnel, any personnel that you worked with?
A No.
Q Okay. Did Peat Marwick actually do a hard copy financial audit report?
A I believe that they did.
Q So they would -- they would have submitted some kind of findings or audit report or something?
MS. SCHWARTZ: Objection.
A I believe that they would.
BY MR. YOUNG:
Q Okay. Have you ever -- let me ask you this: Do you plan to testify in any capacity, whatsoever, with regard to the Mississippi Comprehensive Health Plan that's at issue in this case?
MS. SCHWARTZ: Objection.
A The only place that I've seen that name -- and I believe I understand your question -- is some of their -- it's a claim for some of the costs related to their insurance claims.
MS. SCHWARTZ: Can we go off the record?
MR. YOUNG: Not during the middle -- I mean, unless --

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MS. SCHWARTZ: I think I can clear up something for you if you want me to.
MR. YOUNG: That's fine.
(Off Record)
MS. SCHWARTZ: Mr. Luckett is being offered as an expert witness with regard to expenditures incurred by the Division of Medicaid.
MR. YOUNG: And the Division of Medicaid only?
MS. SCHWARTZ: And the Division of Medicaid only.
MR. YOUNG: So he will offer no testimony as the to Mississippi Comprehensive Health Plan, its operation, anything of that nature.
MS. SCHWARTZ: That's correct.
MR. YOUNG: That's all I was looking for.
BY MR. YOUNG:
Q All right. You left Peat Marwick in 1992?
A I officially retired as of June 30th, 1992. I stayed on with Peat Marwick on a transitional consultant nature for two years following that.
Q So is it -- at that point when you retired you started doing consulting work not only for Peat Marwick, but other entities or individuals?

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A That's true.
Q Okay. Give me an idea of what you still do on a consulting basis for Peat Marwick.
A None.
Q Okay. When did that end?
A June 30th, 1994.
Q Okay. Between '92 and '94, what did you do for Peat Marwick generally as a consultant for them?
A When I left Peat Marwick, I was the only health care partner with Peat Marwick in the Jackson office at that time. My assistant was not a partner. I counseled him on various matters, primarily client-related matters, to give him time to develop closer relationships with the existing clients that we had when I left.
Q So you sort of passed the torch to him.
A That's a fair statement.
Q Other than your work, consulting work, that you did with Peat Marwick for that two-year period, what other consulting work have you been involved in?
A Well, of course, there was Jeff Anderson Hospital that I went to work for.
Q Right.

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A We've gone over that. There are two or three other hospitals that I do a limited amount of work for.
Q Okay. And who would they be?
A Mississippi Methodist Rehab Center here in Jackson.
Q Mississippi Methodist Rehab Center. Okay.
A Greenwood-Leflore Hospital --
Q Greenwood-Leflore --
A -- in Greenwood.
Q -- Hospital. Okay.
A Lawrence County Hospital in Monticello.
Q Lawrence County. That's a county-owned hospital?
A Right. Delta Regional Medical Center in Greenville.
Q Is that -- that's also a county-owned hospital?
MS. SCHWARTZ: Objection.
A To the best of my ability, they are county-owned.
BY MR. YOUNG:
Q Is that the only hospitals that you can think of?
A That's all that come to my mind right now.

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Q I don't want to characterize your work for you, so you tell me if I do try to short cut things. So if it's wrong, please let me know. For these four hospitals that you have identified, do you do the same type of work for them as you do for Jeff Anderson Hospital?

MS. SCHWARTZ: Objection.

A It would be more limited than the work that I do for Jeff Anderson.

BY MR. YOUNG:

Q Okay. Then why don't you tell me what you do for each of these hospitals.

A Let's start off with Greenwood-Leflore Hospital.

Q Okay.

A I go to Greenwood-Leflore Hospital one day a month to review their financial statements to make sure -- to ensure to the best of my ability that they are reasonably correct. I do discuss other financial issues with administration when I'm at that hospital. Nothing specific. I'm just available to consult with them on an as-needed basis.

Q Do you ever look over their Medicaid/Medicare reports?

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A I do do a cursory review of their Medicaid and Medicare cost report. I do not prepare that report.

Q What do you do a cursory review for?

A To see if it appears reasonable.

Q Do you -- how do you tell them that it's reasonable or unreasonable?

A Well, you develop certain expertise after you've been in the industry the length of time that I've been to know whether the -- it's reasonable or not.

Q Well, do you --

A There are certain ratios that you obviously develop, some expertise or general knowledge of the industry.

Q I'm sorry. My question was: How do you tell them whether or not the cost report that they are about to submit to Medicaid is reasonable or not?

A That's an oral communication to them.

Q But they pass that by you before they submit it?

A That's true.

Q Okay. How long have you been doing that for Greenwood-Leflore Hospital?

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A Since my retirement from Peat Marwick.

Q So four years going on five years?

A That's correct.

Q How often is that report submitted?

A Once a year.

Q All right. Any other work that you do for Greenwood-Leflore Hospital?

A No.

Q Okay. Let's go on to -- well, you pick the next one that you want to tell me about.

A Lawrence County Hospital in Monticello -- my trips to them down there may be one, two times a year at the most. Again, it's just a general relationship with them. Again, in their situation, I don't prepare their cost report, but I do review that report with the same thought in mind as to whether it appears reasonable to me or not.

Q Now, Leflore Hospital, Greenwood-Leflore Hospital -- do you know whether or not that's a county-owned hospital?

MS. SCHWARTZ: Objection.

A I believe that's a joint-owned. It's city and county, to the best of my knowledge.

BY MR. YOUNG:

Q Okay. What about Lawrence Hospital?

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A I believe it's a county-owned institution.

Q Okay. So, again, you're reviewing once a year their Medicaid/Medicare cost reports?

MS. SCHWARTZ: Objection.

A That's right.

BY MR. YOUNG:

Q That's right?

A That's right.

Q Okay. What's the next -- which hospital do you want to talk about next? We've got two more left.

A Mississippi Methodist Rehab Center.

Q Okay.

A Again, I review their Medicare/Medicaid cost report. No preparation involved. I do review it for reasonableness and advise them of any concerns that I may have about it.

Q Okay. You do that annually?

A That's correct.

Q You've been doing that since your retirement also?

A That's correct.

Q How about Delta Regional Medical Center?

A Delta Regional Medical Center, I don't know the exact year that I -- I don't know whether

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it was '9- -- it was probably '94 when I first started doing some work for Delta Regional Medical Center, but, again, it's in the area of assisting in the preparation of their Medicaid cost report and Medicare cost report.

Q Okay. You actually helped prepare that report --

A That's right.

Q -- instead of just doing it for reasonableness?

MS. SCHWARTZ: Objection.

A That's right.

BY MR. YOUNG:

Q Okay. One thing I forgot. She's told you that she will be objecting to questions during the course of the deposition. Another item I would like to tell you about is the tendency when you carry on a conversation, for both of us to speak over each other at some times. So let's -- we'll both try to watch it and you let me finish my question, and I'll let you finish your answer. Okay? Because she can't take down simultaneous.

A Okay.

MS. SCHWARTZ: Three of us talking at once.

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MR. YOUNG: Right.

BY MR. YOUNG:

Q All right. So with the first three hospitals that we discussed, you simply reviewed the prepared joint Medicare/Medicaid cost reports for reasonableness. Is that correct?

MS. SCHWARTZ: Objection.

A That's true.

BY MR. YOUNG:

Q Okay. But for Delta Regional Medical Center, you actually helped prepare the joint Medicare/Medicaid cost report?

MS. SCHWARTZ: Objection.

A That's correct.

MR. YOUNG: Can I get you to tell me what the objection is to that question?

MS. SCHWARTZ: It characterized his testimony, and it was tremendously leading.

MR. YOUNG: Well, this is cross-examination.

MS. SCHWARTZ: You can reask the question. I didn't preclude --

MR. YOUNG: I don't want to reask it.

MS. SCHWARTZ: I didn't preclude him for answering. He can -- he can answer the question.

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MR. YOUNG: There is leading -- in Mississippi, there is leading questions allowed on cross-examination.

BY MR. YOUNG:

Q All right. How long have you been doing this work for Delta Regional Medical Center?

A I'm not sure whether I started in 1993 or 1994.

Q For about, then, three years maybe you've actually prepared the joint Medicare cost report -- Medicare -- I'm sorry, Medicare/Medicaid cost report for Delta Regional Medical Center?

A I assisted in the preparation of that cost report.

Q Do you know whether or not that report was submitted to the Division of Medicaid?

A That report was submitted to the Division of Medicaid.

Q Do you know whether Delta Regional Medical Center got reimbursed on the basis of that particular report?

A It is my belief that they did.

Q Okay. Do you have a contract with any of these hospitals?

A No, I don't.

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Q Okay. How is your consulting work -- how do you -- I don't want to know -- get into how much you get paid and all that kind of stuff. I just want to know what -- how you have set up your relationship with them.

A Most of these people I've known for years and years, and it's -- it's just a professional relationship that I have had with them, an acquaintance that I have had with them and it's not a formal contract on any of these four that we have just discussed. It's just a -- I don't know any other way to describe it other than I --

Q They just say --

A They have asked me to do some work. And I do it and I expect to get paid for it.

Q I understand. Who is your client in this case?

A The law firm.

Q Do you consider your client the tobacco industry?

A No, I don't.

Q Is there a reason for that?

A They didn't engage me.

Q You understand, Mr. Luckett, that you're providing testimony on behalf of the tobacco

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industry, do you not?
A It's my understanding that I was engaged by Kalkines, et al. to assist them in defending this lawsuit.
Q Do you understand that you're offering testimony in this case in support of the tobacco industry?
A I repeat what I understand, that I was engaged by the law firm in defending their client.
Q Is the law firm a defendant in this case?
A No.
Q Who is the defendant? Who are the defendants in this case?
A Certain tobacco companies, as I understand it.
Q Have you advised any of your consulting clients of your participation in this lawsuit?
A Not that I recall.
Q Would you have a problem with being retained by the tobacco industry?
A They haven't asked me to be retained by them, so I don't know. I haven't -- I would have to make that decision should I be asked.
Q Do you know who's paying for your services?

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A Yes.
Q And who is that?
A I'm getting -- I am receiving a check from Kalkines, Arky, et al.
Q But you don't believe the tobacco industry is paying your fees in this case?
A I don't know who -- I get the check from the law firm that I am engaged by.
Q How were you first contacted to participate in this lawsuit?
A I got a call from an attorney by the name of Dinetia Newman with Phelps.
Q Dinetia or Dinetia?
A Dinetia. I'm not sure the exact spelling of Dinetia. She asked if I would have any interest in talking with a person by the name of Mike Wallace who is an attorney with Phelps Dunbar here in town about some assistance to the attorneys in this case. I met with Mike Wallace, discussed what my services may entail, had a meeting with John Hay and one of his associates to further discuss it, and I agreed to assist them in this matter.
Q What did they tell you they needed you for?
A It wasn't any one, two, three type items

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discussed with me as to what my role may play. It was more of a general nature in helping them, assisting them in defending this case.
Q And, again, when you say "them," you're referring to the law firm?
A Right.
Q Did they tell you Philip Morris was who they are defending?
A I believe that I heard that along the lines, but I'm not sure that that was discussed at the first meeting.
Q Have you ever worked in Medicaid?
A I'm sorry?
Q Have you ever worked at the Division of Medicaid in Mississippi?
A No, I haven't.
Q Have you ever worked at any Medicaid division in any state?
A No, I haven't.
MR. YOUNG: Off the record.
(Off Record)
MR. YOUNG: Mark this, please.
(Exhibit 5 marked)
BY MR. YOUNG:
Q Before we leave these hospitals that

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you're still doing consulting work for, Delta Regional Medical Center was the last one we discussed. Do you recall that?
A Right.
Q Is that a county or city-owned?
A I believe it's county-owned.
Q Are any of these hospitals DSH hospitals?
A You're talking about Medicaid DSH or Medicare DSH?
Q Medicaid DSH.
A Greenwood and Delta Regional are.
Q Is it your understanding that a portion of DSH payments may be at issue in this case?
A I've had discussions as to what DSH payments represent as payments to the hospital.
Q Well, do you know whether or not the State of Mississippi is trying to recover a certain portion of the payments -- Medicaid payments, DSH Medicaid payments?
A Yes.
Q Okay. Have you advised either Greenwood Hospital or Delta Regional Hospital that you are trying to assist in preventing the State from recovering DSH payments?
A I don't believe that anybody at Greenwood

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or Delta Regional knows that I'm working on this case.
Q As a financial adviser and assistant to these two hospitals, is it not important for them trying -- to try to recoup DSH payments?
A I don't view that as my role with these two hospitals to discuss that matter with them.
Q Then you don't think it's important to tell them that you're trying to prevent the recovery of DSH payments?
A I'm not trying to prevent the recovery of DSH payments.
Q The State's trying to recover a certain portion of DSH payments and you're offering testimony in opposite to the State's attempt to recover Medicaid DSH payments. Do you not think that you're trying to prevent the recovery of those monies?
MS. SCHWARTZ: Objection.
A I'm not sure I understand your question.
BY MR. YOUNG:
Q Well, my question is: Do you think, by offering your testimony, that you're in any way inhibiting the State's attempt to recover Medicaid monies, a portion which are DSH payments?

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A It is not my understanding that the State is trying to recover DSH payments from hospitals.
Q You don't believe that Medicaid -- strike that. We'll come back to it. Can you tell me what a financial audit is?
A A financial audit --
Q In terms of a hospital financial.
A -- is made for the purpose of expressing an opinion as to the fairness of the operation of the hospital and the financial position as of a particular date in time.
Q Is that different or does a financial audit involve a claims audit?
A Repeat your question again.
Q Is a claims audit, for instance, part of a financial audit?
A I'm not sure what you mean by "claims audit." Would you tell me what a claims audit is?
Q Okay. For instance, in your work when you have prepared the Medicare/Medicaid reimbursement reports, you had to put in claims, Medicaid claims information. Is that right?
A The auditor doesn't have anything to do with filing of Medicaid claims. As far as the financial audit is concerned, that's just another

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third-party payor obviously that is reviewed by the auditor that's auditing the financial statements.
Q Well, the financial statement -- revenues on the financial statement are based in part on claims by the hospital submitted to third-party payors. Is that right?
MS. SCHWARTZ: Objection.
A The financial auditor doesn't differentiate between hospital bills in the normal course of a financial audit whether they be Medicare/Medicaid or private pay or commercial insurance.
BY MR. YOUNG:
Q That wasn't my question. What are the sources, then, of the hospital's revenue?
A You mean who are the major payors?
Q On a financial audit what comprises generally the sources of hospital revenue?
A I will attempt to answer your question; and if I'm not clear, ask me again. The major payors of a hospital are Medicare, Medicaid, commercial insurance, private pay. There can be some other contractor services with managed care organizations; but if that didn't answer your question, you are going to have to ask me again.

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Q Okay. It didn't. So I'll ask again. In looking at the financial picture of a hospital in a given year, how do you know what revenue the hospital anticipates receiving?
A The financial audit is not concerned with what the hospital anticipates that they are going to receive, so that is not addressed by the financial audit.
Q Okay. Then you tell me what's addressed by the financial audit, then.
A A financial auditor examines to the extent that they deem necessary the transactions throughout the year for a hospital in order to put in a position to express an opinion on results of operations for whatever period he's auditing and the financial position as of the date that he's auditing.
Q Okay. Now, would that involve expressing opinions as to whether or not the hospital was billing providers correctly and accurately?
A That would be a part of the evaluation of the internal control of the hospital.
Q So, yes? Is the answer yes?
A The answer would probably be yes --
Q Okay.

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A -- if I understand your question.
Q All right. So how would you -- what is that called, then, in your terminology, looking at the billing procedures to make -- making sure that the hospital is accurately billing and receiving its money from providers?
A The financial auditor would review the revenue cycle for that hospital to make -- to give them assurances that the billing is in accordance with hospital policy and so he can gain assurances that there are no significant problems with the system.
Q Well, I thought you told me a second ago that the financial auditor is not interested in revenue at all.
MS. SCHWARTZ: Objection.
A I didn't -- if I -- if that's what you interpreted I said, that's not what I said --
BY MR. YOUNG:
Q Okay.
A -- in my own words.
Q Okay. Well, in looking at the revenue cycle and the billing practices, do they look at each and every claim?
A Absolutely not.

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Q What do they do?
A They review the internal controls that's in place at the hospital to gain assurances that they are being billed in accordance with hospital policy.
Q Well, if they don't look at every claim, do they look at a sample of claims?
A It may be instances where they wouldn't look at any of them, but in all probability, they would look at a sample.
Q Okay. And then what do they do? Tell me what that's called in your terminology.
A Evaluation of the internal control environment of the hospital.
Q That's what you call looking at a sample of claims?
A That would be a part of the evaluation of the internal control of the hospital.
Q Okay. Just give me an example, then, of what they would gather -- how would they decide how many -- what size sample of claims to look at?
A That's a judgmental decision that each auditor would have to make based on his evaluation of the internal control procedures.
Q Okay. Well, let me try to help you with some hypotheticals and maybe we can get generally an idea. Is there a certain number sample size that you would look at depending -- does that depend in any way on the number of claims or the size of the hospital?

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A No.
Q Okay. What does it depend on generally?
A The auditor's own evaluation of the environment, internal control structure, et cetera.
Q Well, have you done this before? Have you looked at a sample of claims before?
A In my earlier years, I have.
Q Okay. Well, in your earlier years when you looked at a sample of claims before, how did you determine what sample size to draw?
A My evaluation of internal control is not a required percent of the total population of that stream that you may be evaluating. It's -- it's left up to the individual judgment of the auditor.
Q Well, I want you to give me an example or an actual case scenario that you worked on where you did a sample -- sampling of claims.
A I can't tell you whether I reviewed 15 bills or 20 bills. I don't remember.
Q Okay. Well, generally did you do it --

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did you look at 100 bills?
A I don't know the answer to that question.
Q Have you ever looked at -- when you're doing a sampling -- when you've ever done a sampling of claims submitted, have you ever looked at 100 claims?
A I don't know.
Q 1,000 claims?
A I don't know.
Q Have you ever looked at two?
A I'm sure I've looked at two.
Q Ten?
A I can't answer that question.
Q Well, I'm trying --
A It's -- you're trying to ask me a question that I can't answer as to how many claims would I typically look at in a sample, and the answer would vary.
Q Okay. And I want to know by how much it usually varies. I'm not holding you to any number that you, you know -- you've been working in this field for 20 years you've told me. Now, I want to know, generally, do you go over 100 claims when you're in a hospital looking at each one?
A I can't answer that question.

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Q Have you ever looked at more than 100 claims when you've done a sampling?
A I doubt it.
Q Okay. Now, at more than 50 claims when sampling a hospital?
A I don't know.
Q Well, do you doubt it, or do you not doubt it? I'm just asking, Mr. Luckett, generally what's done. It's not a trick question. I just want to know, generally, do you look at more than 100, more than 50, more than 20?
A I'm not trying not to answer your question, but I keep coming back. It's left up to the individual as his assessment of the controlled environment in this particular area that he's looking as to how comfortable he may feel as to the possibilities of errors in that field that he's looking at.
Q Okay. What else besides sample size, then, would he be looking for?
A In what?
Q In doing the financial audit. You said, "Comfortable with determining whether or not there's errors in that."
A Depending on your definition of "errors,"

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it may not be anything else that he's looking for.
Q Other than looking at a sample of claims?
A And evaluating internal controlled environment of that particular stream that he's looking at.
Q Well, what is the definition of "error" that you usually work with?
A If there is any type of deviation from what the hospital policy is as far as charges, whether it was billed to the right patient, whether the mathematical accuracy of the claim is right, whether --
Q Now, what is he going to do in order to make his determination to reach an opinion one way or the other about whether or not the hospital's on track or not with regard to the claims?
A He would go back to medical records and ensure that the patient was in there. He would look at charge tickets to make sure that the amount reflected on the bill and the charge ticket agree, that the service was ordered.
Q So he'd go back on that claim and look at each aspect of the claim pretty much, wouldn't he?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:

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Q Wouldn't he?
A That's right.
Q Now, would he look at every claim for that year?
A No.
Q Okay. Now, how would he determine how many claims to look at?
A I can't answer that question. It's not a percent of any number of the field. It's a judgment call by the individual auditor as to how --
Q And that's what I want to know, Mr. Luckett. I don't mean to interrupt you, but that's what I want to know. What is he taking into consideration in reaching his judgment as to how many claims to look at?
A He would evaluate the internal controlled environment, whether there were systems of checks and balances to properly state that particular claim or those particular claims within that cycle.
Q I still don't think you've answered my question.
MR. YOUNG: Could you read back my question, my last question to him, please.
(Record read.)
A I don't know how to answer your question

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any other way. I may not have answered your question.
BY MR. YOUNG:
Q Well, what do you look at when you go in and you want to know before you decide to look at 50 claims, 20 claims? You said you never looked at 100 claims. Is that right?
A I don't believe I said that.
Q Well, have you ever looked at 100 claims --
A I said I doubt that I had.
Q I thought you said you never did on 100. Now, 50, you said you doubted it.
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q So if that's incorrect, let me know.
MS. SCHWARTZ: Objection.
A The record will speak for itself. If I said that, I said it; but I believe that I said I doubt that I would have ever looked at over 100 in any one hospital on a particular cycle.
BY MR. YOUNG:
Q All right. Now, in determining how many -- when you've done this, in determining how many claims to look at, I want to know what you --

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Q Well, let me ask you this: If you -- based upon the few claims out of the total that you review, whatever the number may be, do you draw conclusions as to the whole claim -- the general large pool of claims?
A In most cases that would be correct.
Q So you extrapolate your findings from the small number of claims to the larger pool of claims. Is that right, generally?
A Generally, people don't extrapolate any more. It depends on the type of error that you find. There's a lot of other factors as to whether you extrapolate or not.
Q But that's done?
A Sure.
Q Okay. Why wouldn't you just go back and look at each claim?
A It's not the purpose of a financial audit to determine that the financial statements are precise. The auditor's opinion reads, in my own words, presents fairly the financial operations of the hospital.
Q Yeah, but, I mean, don't you have to -- I mean, in order to say one way or the other, don't you have to go back and look at each claim,

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individual claim?
A Normally that's not done.
Q Why?
A The nature of a audit is that you sample claims. If there were concerns that every claim could be wrong or the frequency of the error could be so great, then you would -- could possibly take another approach to it. You could find yourself in the position that if the nature of the error and the frequency of the error was so great, you could find yourself in a position of not being able to express an opinion on the fairness of the financial statements.
Q Have you ever gone back and looked at every claim?
A No.
Q Do you know if Peat Marwick has ever done that?
A Not within the hospital, I don't believe that they have.
Q But you're able to draw conclusions, nonetheless, even though you haven't looked at every claim?
A That's right.
Q And that's generally acceptable?

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A That's right.
Q It actually would be very burdensome and time consuming to go back and look at each claim, wouldn't it?
MS. SCHWARTZ: Objection.
A It would be burdensome and time consuming, but I want to make the point clear that the auditor can still come to a conclusion that he wasn't able to express an opinion on those financial statements and still not necessarily go back and look at every claim. That would be -- if that were necessary to happen, then what the auditor would probably do would be to instruct the hospital that the nature of the problem is so great that they need to go back and do that themselves. The auditor himself wouldn't do that.
BY MR. YOUNG:
Q Okay. In a situation where you drew conclusions based upon your sampling of the claims, how do you do -- how does that generally work?
A Well, obviously the number of errors that you find in that particular sample, whatever that number might be, is going to influence you -- the type of errors, the amount of errors is going to play a role in what you conclude as to whether that

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particular cycle is reasonable or not.
Q How do you go from your findings on the individual basis to the conclusions as to the whole cycle of revenue?
A You're talking about the revenue cycle?
Q Right.
A Is that right?
Q Right.
A There's no one, two, three process to that -- reaching that conclusion.
Q Just generally, what's done?
A Well, if I examine this sample that you're talking about, and if I don't find any great number of errors, then I get comfortable that that part of the cycle is functioning as it should. And you have to know that simply examining the claims is not the complete cycle insofar as the revenue cycle is concerned. You've got cash receipts as well, but you've got to -- as I understand what we've been talking about, you're talking about the actual bill as it goes out. Now, we've got to get comfortable that that bill is something that was paid or not paid.
Q Well, let's say you found some overpayments, for instance, or -- strike that.

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Let's say you found some -- I don't know what your term for it would be; but if you submitted a bill twice, same claim, what do you call that?

A Duplicate billing.

Q Okay. If you found that in the claims that you sampled, how do you, like, express that as to your total revenue if you find that it's important?

A I think any duplicate bill would be important. I think what I would do first is go back and find out why this occurred. And depending on the circumstances under which that occurred, I may could do some additional work, or I may be satisfied that that was a -- an event that I didn't think would happen very frequently, or it could be that I couldn't draw a conclusion if it was rampant throughout the system, so to speak.

Q Okay. I hand you what's been marked as Exhibit 2 to your deposition.

A Okay.

Q Do you recognize that as your disclosure statement prepared in this case?

A I do.

Q Okay. Did you prepare that?

A I assisted in the preparation of that.

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Q Okay. Who -- did you write it?

A I wrote parts of it.

Q Okay. Why don't you tell me what parts you wrote.

A I had -- this was drafted from my rsum, and I did some -- and I can't remember exactly. I did some -- what I'm going to call wordsmithing to some of the terms.

Q Did you keep a copy of that wordsmithing?

A No.

Q Did you send that to Ms. Schwartz or Mr. Hay?

A I believe I talked to them on the phone.

Q Did you produce that to us?

A I'm sorry?

Q Your draft, your edited draft of your disclosure statement.

A I didn't keep a copy of that.

Q Does anything on here need to be changed, Mr. Luckett?

A Not to my knowledge.

MS. SCHWARTZ: Why don't you let him -- do you only have one copy of this? Because it's hard to ask him questions of a document that's not in front of him when asking questions on the document.

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MR. YOUNG: He probably just got through reviewing it, but I'll ask him.

MS. SCHWARTZ: I don't believe he memorized it.

MR. YOUNG: Well, he wrote it, so I hope he's reviewed it before. That's what he's giving testimony on.

MS. SCHWARTZ: There's a difference in reviewing something and memorizing something.

BY MR. YOUNG:

Q Does anything on there need to be changed?

A Not to my knowledge.

Q Okay. And you agree with everything that's written on here?

A To the best of my knowledge.

Q All right. Did you -- when you say "wordsmithing", did you strike anything from the earlier draft?

A Not in its entirety, I don't think.

Q All right. In its nonentirety, then. When I say "wordsmith," I mean change a -- my interpretation of that is change "a" to "the".

A That's the type of thing that I'm talking about.

Q Well, I get the feeling that you may have

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struck out some portions of it.

A No, no, that's not true.

Q Okay. So there were no substantial -- substantive changes in it?

A That's right.

Q Okay. We discussed earlier, Mr. Luckett, that you -- I believe you said that you had never worked for the Division of Medicaid in Mississippi or any other state.

A I have never been an employee of the Division of Medicaid in this state or any other state.

Q Okay. Did you -- prior to this case, have you ever had any training, formal or informal, with regard to the operation of the Division of Medicaid in Mississippi or any other state?

A Formal training with the operation --

Q Or informal?

A No.

Q Have you ever participated in an audit of the Division of Medicaid in Mississippi or any other state?

A No.

Q Did you familiarize yourself with the information that you're going to testify about

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concerning Medicaid only with regard to your testimony in this case?
A I have reviewed a lot of documents.
Q In this case?
A Right.
Q Prior to this case?
A No.
Q So would it be a fair statement that prior to your preparation for your testimony in this case, you had no knowledge about the internal controls or the workings of the Division of Medicaid in Mississippi?
MS. SCHWARTZ: Objection.
MR. YOUNG: What's the --
MS. SCHWARTZ: Again, you're characterizing this man's testimony. He can answer the question, but I don't like your characterization.
MR. YOUNG: Well, what is my characterization, Ms. Schwartz?
MS. SCHWARTZ: Your characterization is that you -- he did not state that he didn't have any knowledge about the specific internal working controls in the Division of Medicaid.
MR. YOUNG: I asked him did he --

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MS. SCHWARTZ: The record will reflect what he did and didn't say. He can answer the question.
MR. YOUNG: Well, I'm going to ask you -- I don't know what these objections are because they're certainly not as to form. That's a perfectly appropriate question. And I'm going to ask you to, please, before you make an objection, to consider it before it's made.
MS. SCHWARTZ: I assure you I do.
MR. YOUNG: Okay. Now, would you repeat my question back to him, please.
(Record read.)
A I would probably have no knowledge about the internal controls of the Division of Medicaid. Over the years, obviously we communicate some with the people at Medicaid when our hospital clients experience problems with lack of claim payment or items of this nature. But insofar as a detailed review of the operations of the Medicaid, no.
BY MR. YOUNG:
Q You don't consider yourself an expert, do you, Mr. Luckett, on the operation of Mississippi's Medicaid division?
A I consider my -- to the extent that I have

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reviewed these documents as I relate to internal controls or lack thereof, I believe that I can evaluate as to whether those internal controls are adequate or not.
Q Do you think people within the Division of Medicaid might have a better handle on it that work with it on a day-to-day operation than you would be as an outside observer?
A Probably so.
Q Have you talked to any of those individuals in preparation for your testimony in this case?
A No, I haven't.
Q Do you not think -- do you think that might be important, Mr. Luckett, in reaching your opinions in this case to talk to the director of Medicaid, for instance, or some of the people that work in the financial department of Medicaid?
MS. SCHWARTZ: Objection.
A I have reviewed documents submitted to me that were both internal and those prepared by the State Auditor and other agencies regarding the operations of the Medicaid Division.
BY MR. YOUNG:
Q That was not my question. Do you believe

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that it's unimportant for you to discuss the internal workings of the Mississippi Medicaid Division with people that actually work there in an effort to fairly reach your opinions in this case?
MS. SCHWARTZ: Objection.
A If I were going to perform a financial audit of the Division of Medicaid, certainly that would be one of the processes that we would go through to evaluate internal controls on the Medicaid Commission.
BY MR. YOUNG:
Q Well, you're reaching conclusions, aren't you, Mr. Luckett?
MS. SCHWARTZ: Objection. Now, you know that this witness is not allowed to speak to people at the Division of Medicaid as a witness for the defense. As an expert witness, if he called up Helen Wetherbee and had a discussion with them, you would hit the roof.
MR. YOUNG: Well, that didn't prevent Ms. Godbout from doing it, did it, Ms. Schwartz?
MS. SCHWARTZ: I was not at Ms. Godbout's deposition, and I don't know what transpired there, but I'm just talking about this witness right here.
MS. YOUNG: I'm not saying whether he can

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or cannot do it. My questioning is: Is it appropriate for him to make his evaluation as an auditor of 20-some-odd years -- does he take visiting with the employees, et cetera, into account in reaching his conclusions? I think he said earlier that he always does that when he's auditing a hospital and reaching conclusions.

BY MR. YOUNG:

Q Now, I'm simply asking you, Mr. Luckett, that when you review and make opinions, recommendations and findings about a certain program, isn't it true that you generally, in your evaluative process, like to talk to those in charge and that are handling the program on a day-to-day basis?

A That's generally a part of evaluating internal controls, yes.

Q And you did not do that in this instance, did you?

A No, no.

Q I hand you what's been marked as Exhibit 4 to your deposition.

A Okay. That's a long list.

Q Yeah. Did you prepare that index?

A No.

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Q Okay. I will also like to hand you what's been marked as Exhibit 5. And for the record, that is a summary we've prepared of the different boxes of documents we received that apparently were not produced by the State that you also reviewed.

And What I'd like to know is: The documents identified on Exhibit 4 -- that index was provided by your counsel here today. Those documents are documents you reviewed that were prepared by -- or produced by the State of Mississippi. Is that right?

A These are documents -- if this list is correct, and I will assume that they are -- that I had at my disposal to review.

Q That were produced from the State of Mississippi?

A I assume so.

Q Okay. What about these documents that were in the other -- the boxes that were sent to us? Where did you retrieve those documents from?

A These documents were furnished to me by counsel.

Q Okay. Did you do any independent search for documents --

A No.

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Q -- for this case or for your testimony in this case?

A No.

Q So in order to formulate your opinions in this case, you counted on what documents defense counsel sent you?

A That's right.

Q Well, do you know if you've seen everything?

A I've seen everything that they sent me.

Q Did they send you the index of all the documents that the State of Mississippi has produced from the Division of Medicaid?

A No.

Q So as we sit here today, you don't know whether there are other documents on there that may be important to your testimony that you've not seen, do you?

A No, I don't know that.

Q Well, Mr. Luckett, out of fairness, wouldn't you want to see all the documents that the State's produced and you make the determination of what you want to see versus defense counsel telling you what's important for you to see in order to reach your opinions in this case?

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A I believe that counsel furnished me the documents that they are asking me to assist them with.

Q That's not my question, Mr. Luckett. I said: Out of fairness -- and after all, you're here to tell the truth and be fair, aren't you?

A I'm going to tell the truth.

Q And be fair?

A I am.

Q Well, in properly evaluating the Division of Medicaid, wouldn't you like to see all the documents that the State has produced with regard to the Division of Medicaid, and you select what you want to look at in order to determine what may or may not be important?

A I'm not trying not to answer your question, but your question was for me to evaluate the Division of Medicaid. That's not my understanding of what I'm charged to do.

Q You're not evaluating the Division of Medicaid?

A Not in its entirety.

Q I see. Well, as to the limited areas?

A I assume that I received all the documents that were necessary for me to draw my conclusions

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about those limited areas.
Q Have you asked to see all documents that were produced by the Division of Medicaid?
A I didn't ask that specific question, no.
Q Have you reviewed the deposition of the director of the Division of Medicaid?
A I have.
Q So that needs to be added to the list too. Is that correct?
A It was my understanding that it was.
Q It may be on there. Can I see that?
MS. SCHWARTZ: Off the record.
(Off Record)
BY MR. YOUNG:
Q In your disclosure statement, if you could take that for a second, please, you say that you will testify concerning the reliability of the internal controls utilized by Mississippi. Okay? Now, I'm assuming utilized by Mississippi Medicaid. Is that what you're talking about?
A Right.
Q Now, if you can, please, for me, itemize what internal controls you're talking about.
A It would be limited to those internal controls that were addressed in these documents that

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I have reviewed. I don't know if I can cover exactly all of those that I have reviewed, but it would be in the -- related to payment rates. It would be related to items such as covered services. It would be -- it would be relying, in part, on the State Auditor's evaluation of internal controls in the areas that they had listed. But to give you an exact each and every one, it's difficult to do.
Q Well, we're going to try to do it today. What is a control, an internal control as you put it in your own words here?
A In my own words, internal control is a set of controls and operating procedures that, properly operated, will reduce to a relatively low risk that a material misstatement in a financial statement will not go undetected by those persons performing the task in the normal course of their duties.
MR. YOUNG: Can you read that back to me?
(Record read.)
BY MR. YOUNG:
Q Is there a difference between internal and external controls?
A Yes.
Q What is that difference?
A External controls would be those controls

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that you would expect from someone outside of the entity in which you are auditing. They are more of a general nature than internal controls would be.
Q All right. And believe me, I'm not trying to be difficult, Mr. Luckett. But you state here you will testify concerning the reliability of the internal controls utilized by Mississippi, and we've already discussed that you meant Mississippi Medicaid. Is that right?
A That's right.
Q Now, please identify for me, sir, the internal controls utilized by Mississippi Medicaid.
A Internal controls for every entity is going to be different. Internal controls have to be established to adjust to the particular environment of each individual entity. Some entities may have a lot more different internal controls than another entity. There may be different levels of internal controls.
The controlled environment with the Division of Medicaid that I think that we are reviewing in this matter has to do with payment of claims. It could deal with eligibility. It could deal with third-party liability area. Any other -- there could be other areas.

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In my definition of payment of claims could -- not only would there be hospital claims, but all type of expenditures of the Division of Medicaid. I don't know what all those controls that Division of Medicaid may have had in place. That would take a -- you would have to have determined those at the time, and those can differ each year. You would have had to have been there at the end of that particular year or cycle in which you evaluated those controls to determine precisely the ones that they had in place.
Q And you weren't there?
A I wasn't there.
Q In fact, you can't itemize for me on a given year what internal controls were in place at the Division of Medicaid, can you?
A The controls -- some of the controls were disclosed to me in the documents that I reviewed.
Q That the defendants selected. Right?
A That the -- the documents that were submitted to me through the attorneys. Right.
Q Now, do you know what period the State's seeking reimbursement for Medicaid expenditures in this case, Mr. Luckett?
A I believe it goes back to 1970.

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Q Okay. Let's start with 1970. And if you'll itemize for me the internal controls that were in place at the Division of Medicaid.
A I have very few documents, if any, relating back to 1970.
Q Do you recall any internal controls that were in place in the Division of Medicaid in 1970?
A I can't tell you what controls they had in place in 1970.
Q Can you tell me for 1971?
A No.
Q '72?
A I can't tell you all the controls they had in place for any year in question.
Q Including 1996?
A I can't tell you all controls that they may or may not have had in place.
Q So you really -- this first sentence in your disclosure statement is inaccurate. You're not going to testify about what internal controls were utilized by the Division of Medicaid, are you?
A Internal controls utilized that were brought to my attention.
Q You say the internal controls utilized by Mississippi. You don't know what all the internal

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controls are utilized by the Division of Medicaid, do you?
A I know some of them.
Q Do you know all the internal controls utilized by the Division of Medicaid in Mississippi for any given year?
A No.
Q Do you consider that important, Mr. Luckett, in reaching your opinions in this case?
A Not particularly.
Q You don't consider that important?
A No.
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q So when you go to audit these hospitals, when you audited the hospitals, did you say -- did you say, "I don't need to know all your internal controls"?
A We may not look at internal controls in every area when we audit a -- do a financial audit of a hospital.
Q Well, do you know all the internal controls related to -- what area are you going to testify in this case concerning Medicaid, Mr. Luckett?

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A I can't give you all the specific areas that I may be asked a question about.
Q Well, do you generally know?
A It could be the claims payment, the third-party liability, a number of other areas.
Q All right. Okay. Well, let's go down to sentence number 2 in your disclosure statement then. Maybe this will help you. "He is expected to testify that those controls", whatever they may be at this point, "which relate to eligibility" -- let's stop there. What controls did the Division of Medicaid have in place concerning eligibility?
A I don't know what all controls they had in place. I do know, based on the documents submitted to me -- submitted to me, that some of the controls that they either thought they had in place or didn't have in place weren't functioning properly.
Q Okay. Tell me which controls, by name, that the Division of Medicaid had in place for eligibility.
A I don't know all of those.
Q Can you name me one, Mr. Luckett?
A I'd have to go back and review the documents to isolate one.
Q Well, I'm sorry, Mr. Luckett. And I'm not

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trying to be difficult here, okay. But you are pretty much going to try to trash the Medicaid system, and you've apparently reached your conclusion already. That's what this disclosure statement does. Now, in reaching your conclusions, you had to draw your opinions from somewhere and something you've reviewed. This is real basic, Mr. Luckett, and I want you to itemize for me what internal controls you're aware of that the State -- the Division of Medicaid had concerning eligibility.
MS. SCHWARTZ: Objection.
A I would think that one of the controls they had in place that they would only issue cards to those people who were eligible for Medicaid.
BY MR. YOUNG:
Q What is that called?
A On the issue of cards?
Q Yeah.
A The entitlement cards?
Q Yeah.
A That would be an internal control.
Q What's the program called?
A I beg your pardon?
Q What's that control called?
A It would be an internal control procedure

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to issue only eligible recipients cards.
Q What year was that in place -- put in place?
A I would hope it would have been in place from the beginning.
Q What year was that put in place?
MS. SCHWARTZ: Objection.
A I would assume year one.
BY MR. YOUNG:
Q In 1970?
A Or whenever the program started.
Q Okay. Now, I don't want you to assume. I want you -- you talk about you're going to say something from an historical perspective. So I want to know after you've evaluated the Medicaid system and these internal controls when this card verification went into place.
A I don't know when it went into place.
Q Do you know for sure whether or not it is in place?
A I know that it should have been in place.
Q That's not what my questions are, Mr. Luckett, and we're going to be here a lot longer than 6 o'clock. You can tell me you don't know. There's nothing wrong with saying you don't know,

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Mr. Luckett. So I'm going to ask you: What eligibility controls do you know were in place within the Division of Medicaid?
A I don't know.
Q For any given year, you don't know?
A No.
Q Now, the next thing you say is claims processing and reporting. Please identify for me which controls were in place for claims processing and reporting.
A I don't know.
Q For any given year?
A That's right.
Q You don't know?
A I don't know.
Q For third-party liability, which is the next item you listed on your disclosure statement, what internal controls were in place within the Division of Medicaid?
A I don't know.
Q Then you go on to say that they have historically had widespread systematic problems. These three internal controls or whatever internal controls there may be related to these three areas, which you don't know about, you now go on to say

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that they have historically had widespread systematic problems. Please identify for me the widespread -- historically widespread systematic problems.
A Based on the documents that were furnished to me, there was evidence in there that those controls that are prudent that a person should have had in place were either not in place or not functioning.
Q All right. First of all --
A I can give you some examples of that if you would like for me to.
Q We'll get to that in a second. What does the federal government require that the Division of Medicaid have in place in terms of internal controls for eligibility?
A I don't know the exact federal requirements for that.
Q Do you know whether --
A I don't know that it is such a thing.
Q Do you know whether or not the Division of Medicaid had in place the federally required internal controls related to eligibility?
A I don't know that.
Q Do you know whether or not there were

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external controls in place to evaluate eligibility within the Division of Medicaid in Mississippi?
A I don't know that.
Q What internal controls did the federal government require concerning claims processing and reporting for the Division of Medicaid in Mississippi?
A I don't know those specifically.
Q Do you know whether or not the Division of Medicaid in Mississippi complied with the federal regulations or guidelines concerning internal controls on claims processing and reporting?
A I don't know that specifically.
Q Do you know whether or not there were external controls in place to -- for claims processing and reporting with regard to the Division of Medicaid in Mississippi?
A I don't know that specifically.
Q What regulations and/or guidelines -- what internal controls -- strike that. What internal controls does the federal government require concerning third-party liability for the Division of Medicaid in Mississippi?
A I don't know that specifically.
Q Do you know whether or not the Division of

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Medicaid in Mississippi had in place required internal controls that were required by the federal government?
A I don't know that specifically.
Q Do you know whether or not there were external controls in place with regard to third-party liability for the Division of Medicaid in Mississippi?
A I don't know that specifically.
Q Now, you've said "specifically" on all three. Generally, do you know either?
A No.
Q Could you outline for me, please, the historical -- historically widespread systematic problems that the eligibility internal controls have had?
A Based on documents that have been furnished to me, there is considerable memoranda by the Division of Medicaid personnel about problems that they were having with the various physical agents in duplicate cards being given to recipients, and the fact that there were cards with several Medicaid numbers on a card. There were problems with cards with both the mother and baby member being on the same card. Items such as this.

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Q Do you know where they get -- when and where they get -- a recipient gets his Medicaid card?
A That card is mailed out, as I understand it, by a fiscal agent.
Q Do you know where they go to apply for it?
A It could be -- I think it could be several different places. It could be the -- the county welfare office would be probably the most likely place, I would think.
Q Do the hospitals check that card when they treat a Medicaid recipient?
A That recipient should present that card upon admission either as a outpatient or an inpatient admission. The hospital would take that card and that number and try to verify coverage of that person.
Q So the hospital would? Correct?
A I beg your pardon?
Q The hospital would attempt to verify --
A Right.
Q -- that coverage? And the hospital would bill Medicaid based upon its verification of that card. Is that correct?
A That's true.

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Q And then the hospital would submit, on an annual basis, its reimbursement to the Division of Medicaid?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Is that right?
A No, no. The hospital will submit a bill upon discharge of treatment of that patient to a fiscal agent for reimbursement of that particular bill.
Q What if it was Medicaid?
A Huh?
Q What if it was Medicaid?
A I'm talking about Medicaid. That's what I'm referring to.
Q That's right. So who would the hospital submit the bill to?
A To the fiscal agent.
Q That's administering the plan?
A Right.
Q That bill would be part of this omnibus report that's submitted at the end of the year?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q The joint Medicaid/Medicare?

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A The report that you're speaking of has nothing to do with what may or may not be paid, at least directly, for each particular bill that is sent in from the hospital.
Q Okay. What does it have --
A Those bills are adjudicated when the fiscal agent receives those bills.
Q When did the card -- when did Medicaid cards first start getting issued in Mississippi?
A I don't know the exact date. I don't know the approximate date. I would assume that they had cards back at the beginning of the program to identify them.
Q Do you know what year?
A No, I don't.
Q What documents are you relying on to support your opinion with regard to the duplicate cards to recipients?
A I would have to go back and review in detail the documents that I drew my general conclusions from. I didn't make notes in reviewing each and all of these documents.
Q Well, do you generally know where you would have gotten that information?
A It would have been out of a memorandum

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that was obtained out of the Division of Medicaid.
Q What memorandum?
A Well, I'd have to go back and review each memorandum. I'm sure it's a lot more than one document that addresses eligibility.
Q Do you know?
A I'm sure there's more than one. I don't know the exact number.
Q Well, did you check to see whether or not the Division of Medicaid corrected for this problem?
A I didn't make an on-site inspection?
Q Well, did you ask for documents that may indicate whether or not the Division of Medicaid attempted to correct for this problem?
A There would be discussions to that nature in the documents that I would have reviewed.
Q Do you know whether they did?
A In some cases, I'm sure they did. And other documents would discuss the fact that it was either corrected or it needed additional attention.
Q Please quantify for me, please, in dollar terms, the impact that this item would have had on total expenditure.
A I have no way of knowing.
Q All right. Tell me another historically

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and widespread systematic problem that you found with regard to eligibility, the internal controls for eligibility. And, by the way, what's that internal control that you just talked about with regard to duplicate cards? What's the internal control on duplicate cards?
A That was the one that I thought that we was talking about eligibility there.
Q Yes, sir. Now, did they have an internal control to check to make sure that more than one person is not getting issued a card, the same card?
A I would -- prudent business would tell me that you don't issue more than one card to an eligible person.
Q Well, Mr. Luckett, do you know whether the Division of Medicaid had an internal control to make sure that more than one person didn't get the same card?
A I haven't seen that, but that was indicated to me in the memorandums that I read.
Q Well, what was the name of that internal control?
A That internal control probably didn't have a name.
Q Well, how was it set up?

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A I don't know.
Q Who was head of it?
A I don't know.
Q Please give me another example of the historic and widespread systematic problem with the internal controls related to eligibility.
A Another example that I saw in there was one card having more than one number on it. This was discussion in a memorandum out of the Division of Medicaid office.
Q Other than the card issue, any other examples of historic and widespread eligibility internal controls problems with internal controls related to eligibility?
A None come to my mind right now.
Q Please identify for me the historical and widespread systematic problems that you're going to testify about concerning the claims processing and reporting.
A I will give you some of the ones that come to my mind. It may not be an all-inclusive list.
Q Well, I'd like you to give me an all-inclusive list because I don't want to, you know, find out you're going to say something else at trial.

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A I understand.
Q So first of all, what are the -- we might have already covered this. You don't know the internal controls that were implemented by the Division of Medicaid concerning claims processing and reporting, do you?
A Not all of them.
Q Well, do you know some of them?
A Yes.
Q Okay. Please identify for me, by name, the internal controls that the Division of Medicaid in Mississippi had in place for claims processing and reporting.
A One of the ones that come to my mind is -- at least in later years they had a 30-day limit as to the number of days per year for Medicaid eligibles for hospitalization. There was some exceptions to that, newborn and children, but by and large if adults -- they would limit it to 30 days in the hospital per year. There were occasions during this period of time that I looked at where more than 30 days a year were paid. Discussions in memoranda that I saw said that they had a control that would detect payments from recipients for more than 30 days. That control either wasn't in place by the

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fiscal agent or wasn't operating properly.
There was considerable controversy about that particular item because there were several million dollars that they discovered had been overpaid to providers related to that issue, and it was a matter that was serious for the particular hospital.
Q What was the name of that internal control?
A Days of care for eligible recipients shouldn't exceed -- the payments shouldn't exceed 30 days for a fiscal year.
Q Do you know how that control was set up?
A Based on the documents that I read, it was supposed to be controlled through the computer system to not pay those claims in excess of 30 days.
Q Do you have any expertise on the Medicaid management information system?
A Not other than what I have read in these documents.
Q Pardon me?
A None other than what I've read in these documents.
Q You have no personal experience with the Medicaid management information system, do you?

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A No.
Q Do you know how it operates or runs?
A I know it's a computer system.
Q Well, I know it's a computer system.
A I personally couldn't operate it.
Q You couldn't operate it?
A Personally, no.
Q You don't know enough about the computer system to comment one way or the other, do you, whether it's good or bad?
A I know from -- based on the documents that I saw, whether they had what I would consider internal controls built within that system.
Q Name for me the internal controls built within the MMIS system.
MS. SCHWARTZ: Wait until you sit down to answer.
(Short Pause)
A I can't name for you all of the controls that were built within that system.
BY MR. YOUNG:
Q Do you know?
A I just gave you an example of the ones that, in my judgment as an accountant, should have been in the system that either wasn't in the system

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or wasn't functioning properly.
Q All right. We'll get to that in a second. What did the federal government require to be in the system?
A I don't know all of the requirements.
Q Do you know whether or not the federal government certified the MMIS system in Mississippi?
A Yes, I do.
Q Did they?
A Yes, they did.
Q Do you know whether or not the Division of Medicaid actually put in voluntary -- other voluntary controls with regard to its MMIS system that weren't even required by the federal government?
A I'm sure they did.
Q Well, from your experience, how many computer systems have you set up, computer accounting systems have you set up?
A I don't -- that's not my area of expertise in setting up computer accounting systems.
Q Well, what, then, should have been in place in the MMIS computer system that, in your opinion, was missing?
A I gave you one example, which is just one

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of several.
Q Which was what?
A The 30-day limit edit to review payments beyond the approved number of days per year.
Q Well, was the problem caught or identified?
A That particular problem was caught by the State Auditor about -- I don't know how long after the problem occurred.
Q The problem was identified by the State Auditor. Is that correct?
A The problem was identified by the State Auditor. But let me take back to what my definition of internal controls was, that it would be detected by the person performing their duties in the normal course of operations.
Q Now, and the State Auditor would be an example of an external control. Is that right?
A That's right.
Q So the Division of Medicaid had not only internal controls, but also external controls. Isn't that right?
A That's right.
Q And the purpose of having an external control is to do exactly what happened in that

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particular case. When the internal controls failed, the external controls identified the problem. Isn't that right?

A I don't view the financial audit or the single-leg audit, whichever one you want to talk about in this case, as being a primary internal control procedure.

Q You're talking about the State Auditor?

A Uh-huh.

Q I said external control.

A He would be an external control.

Q So the fact is the Mississippi Medicaid system had in place both internal and external controls, didn't it?

A They did.

Q And, in fact, the external control served its purpose by identifying problems that arose that the internal controls did not catch. Isn't that right?

MS. SCHWARTZ: Objection.

A The State Auditor --

BY MR. YOUNG:

Q Isn't that right, Mr. Luckett?

A The State Auditor caught this error that I'm referring to.

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Q So the external control served its purpose and caught something that the internal controls didn't pick up. Isn't that right?

A That's right.

Q Do you know whether or not the problem was corrected, Mr. Luckett?

A That particular problem was finally resolved. Now, whether it was resolved to the exact dollar amount, I don't know; but that was a resolution to that particular problem.

Q And do you know -- and I think you said that the problem that was experienced was that overpayments were made. Is that right?

A In this particular case, that was.

Q Do you know where those overpayments, if they were retrieved, would have been reported by the Division of Medicaid?

A The fiscal agent recouped that money from the providers that had been overpaid.

Q And do you know whether or not those overpayments were reported by the Division of Medicaid and credited to total expenditures?

A I would assume that they were.

Q Do you know where that report would be?

A No.

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Q Do you know whether or not the State of Mississippi took that into account in arriving at its damages in this case?

MS. SCHWARTZ: Objection.

A I would think that they didn't, but I don't know that for sure.

BY MR. YOUNG:

Q You don't know. Well, do you think that they didn't?

A They shouldn't have.

Q They shouldn't have taken overpayments into account?

A I'm sorry. I was opposite of what your question was. I believe that they reduced the expenditures by those recoveries.

MS. SCHWARTZ: You want to -- what time do you think you want to take a break for lunch?

MR. YOUNG: 12:30.

MS. SCHWARTZ: It's 12:05 now.

BY MR. YOUNG:

Q Mr. Luckett, other than the example of the 30-day hospital limit, do you know when the 30-day hospital limit regulation went into place?

A That's determined by each state, and that varies from year to year. It has been 30 days for

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several years now; but as I understand it, that's a day limit that each individual state can set. I recall at one period of time it was 20 days. So that number does change. It's not federally mandated, as I understand, required.

Q It's not?

A No, it's not required by the federal people.

Q Other than that example, can you give me any other historical and widespread systematic problems concerning the claims processing and reporting of the internal controls?

A There were other -- yeah, there were others similar to that having to do with the -- for example, the drug program. I read documents that these certain drugs had a limit as to the number of prescriptions per month. And in this particular case that I was reading it was five prescriptions per month, and there wasn't an edit in there to prevent more than five prescriptions being paid for a month. And it was discussion about the fact that there were instances of this not happening. There are a lot of other ones.

Q Well, we're going to get to them. So what were the five -- when did the five prescription

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limit go into place within the Division of Medicaid?
A I don't know exactly.
Q Well, how was the problem identified?
A The document that I read, which was a memo from Jan Larsen about this particular one --
Q She works in Medicaid, doesn't she?
A Right.
Q Or did at the time?
A I believe -- she was at the time this memo was written. I don't know where she is now. She maybe still there. I don't know.
Q So she caught the problem in the ordinary course of her business, didn't she?
A This was -- no, she didn't.
Q Okay. Tell me.
A This was a memorandum about the performance of First Health against the contract. It was sort of a historical evaluation of how First Health was performing against the contract. This was one of the areas that she addressed in that memorandum dealing with --
Q How was the problem concerning the drug issue that you identified, identified by the State of Mississippi?
A That particular -- that wasn't addressed

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in any specificity in this memorandum that I read. I don't know exactly how it was discovered, but --
Q So one of the -- it could be that one of the internal controls or external controls could have picked that up. Is that right?
A It very well could have.
Q In fact, that's how it would have been brought to their attention. Isn't that right?
A Not necessarily.
Q Well, then, how else besides internal controls and external controls -- what other controls are in place that would identify a problem?
A Well, there could be some reports that were generated out of the computer that they were reviewing to see that more than five prescriptions on this particular class of drug were being issued per month.
Q Well, people actually reviewing the claims data is another type of control, isn't it?
A That's right.
Q So --
A I don't know how that particular error was discovered by Medicare.
Q But it was identified, wasn't it?
A Right.

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Q Now, how much -- do you know -- can you quantity for me in dollars how much impact that particular problem you identified --
A I have no way of knowing.
Q -- had on total Medicaid expenditure?
A I have no way of knowing.
Q Do you know whether or not the Mississippi Medicaid program corrected for that problem?
A I saw an action plan to correct that in this memo. Whether that was ever corrected, I don't know, but it was their intent to correct it.
Q What year was that?
A This memo was dated in February of 1993, I believe.
Q Did you look -- did you ask to see for the Medicaid index -- all the documents that the State of Mississippi produced for documents that would show you whether or not they ever corrected for that problem?
A I didn't see this -- that particular problem in any of the documents that I read as being a problem.
Q So, to your knowledge, then, it must have been corrected for?
MS. SCHWARTZ: Objection.

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A To my knowledge.
BY MR. YOUNG:
Q Is that right?
A I don't know that it wasn't corrected.
Q Well, would you have expected to see that issue surface again in other documents had it not been corrected?
A Had it came to their attention, I would expect it to.
Q Well, would they have lost attention to it if they identified it at one time?
A They could have.
Q Do you know whether they did?
A I don't know whether they did.
Q Have you looked or done any kind of investigation to determine whether or not they did, in fact, correct for it?
A No.
Q And you don't think that's important in drawing your conclusions in this case?
A No.
Q Okay. We've got the 30-day stay limit, the drug program issue. Give me another example.
A There were some other problems in the drug-related area having to do with First Health

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reimbursing for drugs that had been taken off the formulary for all practical purposes.
Q The what?
A The formulary. They have a formulary that lists drugs that are covered by the Medicaid program. Some drugs have been discontinued or out of date or not approved by the feds. They make changes to this master listing of drugs. It was some drugs in this same memo, not by name, that were supposed to have been taken off that formulary that hadn't been taken off. They were being paid for.
Q So that problem, again, was identified?
A That particular problem was identified.
Q Do you know whether or not the State of Mississippi corrected for that problem?
A As far as I know, they did.
Q Can you quantify me -- for me in dollars the impact that this issue that you've just raised had on total Medicaid expenditures?
A That I cannot identify.
Q Give me another example.
A There was another problem in the drug area that had to do with some rather expensive drugs. They were supposed to have preauthorization for dispensing that apparently, according to the memo

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that I read, wasn't -- the preauthorization wasn't required before those drugs were paid for. That seemed to be -- it wasn't just one instance. It was a problem with the computer checks and controls making sure that those were preauthorized before paying for those drugs.
Q Who identified that problem?
A This was addressed. Now, who identified it, I don't know. This was in the same memorandum that was written by Jan Larsen.
Q Do you know whether it was corrected?
A I don't know.
Q Do you know the dollar amount -- can you quantify for me in dollars the impact this issue would have on the total health care expenditures by Medicaid?
A I don't know the exact amounts. She used some language, verbiage in her memoranda that said -- that indicated to me that it could be several hundred thousand dollars.
Q Do you know whether it was ever corrected?
A I don't know.
Q All right. Anything else? We're dealing with claims processing, historically widespread systematic problems.

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A Well, insofar as the hospital rates were concerned, without exception for the years that I had documents, there had been problems with proper rates for hospitals.
Q What documents are you referring to?
A I'm referring to -- one source would be the results of the State Auditor's findings in the hospital rate setting area. That would be discussed in their letters back to the Division of Medicaid.
Q Were they paying the hospitals too much or too little?
A It went both ways.
Q It went both ways?
A Right.
Q So it could have been an overpayment of expenditures or underpayment of expenditures?
A That's right, but it was the wrong amount --
Q But it went both ways?
A -- according to these documents.
Q It went both ways.
A Right.
Q The problem was identified?
A In most of these cases, these were errors noted by the State Auditor.

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Q External control?
A The State Auditor identified them.
Q Is he an external control?
A I think he is.
Q Okay. So the external control caught this problem.
A That's right.
Q Do you know whether or not it was corrected?
A I don't know that it was corrected.
Q Do you know whether it -- do you know whether it wasn't corrected?
A I don't know that it wasn't corrected. I don't know.
Q Can you quantify for me in dollars the impact this had on total Medicaid expenditures?
A No.
Q All right.
A There were similar problems with nursing home rates being overstated or understated.
Q Could have gone either way?
A Could have gone either way.
Q How was the problem identified?
A The ones that I'm referring to were identified by the State Auditor.

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Q External control caught those. Right?
A That's right.
Q Do you know whether they were corrected or not?
A I don't know.
Q Can you quantify for me in dollars the impact that this issue would have had on total Medicaid expenditures?
A No, I can't quantify even the ones that were in their tests that they did. There could have been others, obviously, that wasn't in that test that could have been errors in as well.
Q Do you know?
A I don't know.
Q That would just be speculation on your part. Right?
A That's right.
Q Any other historical and widespread systematic problems in the claims processing and reporting?
A Well, there were considerable memoranda in that it happened for over several years insofar as a gap package that Medicaid -- the Division of Medicaid was to prepare.
Q What's the gap package?

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A That's a -- in my own words, a package that the Division of Medicaid gives to the State in order to use -- to consolidate that agency into the State's --
THE WITNESS: Go off the record for a minute.
MR. YOUNG: That's fine.
(Off Record)
BY MR. YOUNG:
Q What is a gap package?
A The gap package is a package that the Division of Medicaid is to prepare to give to the Department of Finance to consolidate their operations into the State's financial statements.
Q And what are you basing your -- you said they have had problems?
A The State Auditor has written a management letter to the Division of Medicaid for some five or six years in a row telling them that the gap package that was submitted to these -- to the State Department of Finance was inaccurate, that they needed -- they were in error. They talked about some estimates that had been made in those gap packages insofar as the claims were concerned, and they were recommending that more diligent care be

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taken in operation of those.
Q Can you show me what memo that is?
A I would have to have -- if you can give me a --
Q Where's that index?
A -- a State audit report.
Q I tell you what, during lunch, our lunch break, if you can try to identify for me. Okay?
A Okay.
Q About five more minutes. Okay. Anything else?
A I'm not prepared. I didn't come here prepared to make every single exception that I read in that available to you. I don't mean to --
Q In all fairness, I am here to find out what you're going to testify about. So if you think of any more let me know.
A I will.
Q But I can count on these being your big ticket items, so to speak?
MS. SCHWARTZ: Objection.
A Let me see if I can think of some more before -- not -- I will let you know before the day is over what others.
BY MR. YOUNG:

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Q And if you don't, I'm assuming that there are no others.
A No others, major ones.
Q Do we understand each other?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Do we understand each other, Mr. Luckett? Do you understand?
MS. SCHWARTZ: I'm going to say that first of all, document production in this case is ongoing, and we haven't gotten all the documents that we have requested, including significant documents that were asked at Helen Wetherbee's deposition. As of the time I left New York on whatever day it was, Tuesday, we hadn't gotten those documents. Whether he's going to have additional things to say based on future document production, he can't say about that.
MR. YOUNG: I'm not asking him about anything he hasn't seen right now. I'm asking on his review of what he's reviewed so far in these case, are these the major ones or are there other ones? And I want to know before we leave today. And if he doesn't tell me, I'm assuming there are no other ones based upon what he's reviewed today.
BY MR. YOUNG:

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Q Now, Mr. Luckett, are there any others that come to your mind -- historic widespread systematic problems or deficiencies concerning claims processing and reporting?
A There was considerable discussions in the memoranda about the HCFA-64 as to whether that report was properly stated.
Q "Properly stated," what do you mean?
A The HCFA-64 classifies payments in the various categories. That's of concern as to whether those payments were classified in the proper categories. But I think this goes back and really touches on some of the things that we talked about, though, at least in my mind, as to the proper payment of claims and classification of those claims.
So whether you're trying to ask me will I ever bring this up again, I don't know because I don't know what your question is.
Q Well, I want you to tell me what documents you're -- regarding this HCFA-64 are you referring to?
A I would think it would fall under the area of the proper payment of claims, and we've talked about that there are areas that claims have been

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improperly paid.
Q And do you know whether or not any of these claims have been corrected for, these improper payments that you're talking about have been corrected for?
A I don't know what all improper payments have been corrected for or if that's all of them or not.
Q You don't know, do you?
A No.
Q In fact, are you going to testify concerning the HCFA-64 reports?
A I will be making some reference to that report as to whether the claims --
Q How many HCFA-64s have you reviewed from the Division of Medicaid?
A I have made a cursory review of one HFCA-64 report.
Q Cursory review of one?
A Uh-huh.
Q How long has the HCFA-64 report been in existence?
A I don't know.
Q How long -- do you know whether the State of Mississippi's HCFA-64 is in compliance with the

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federal regulations?
A I don't know.
Q Have you ever audited a HCFA-64 report?
A No, I haven't.
Q How is the HCFA-64 report used by the Division of Medicaid?
A To report the -- I have made testimony from others that I have read refer to buckets of claims payments. I refer to category of claims payments whether they are -- a bucket could be mental illness or retardation program or whatnot. It's a type of program that they covered.
Q Do you know what the HCFA-64 is used for?
A To report the expenditures of the Division of Medicaid to HCFA-64 is my general understanding of what it is used for.
Q Do you know whether or not that report is certified?
A I don't know.
Q You've reviewed one? Is that correct?
A I made a cursory review of one.
Q Which year?
A I believe it was probably -- I don't know the exact year. I don't remember.
Q Well, tell me.

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A I don't remember the exact year.
Q Well, are you going to say all HCFA-64 -- hold on, Mr. Luckett. Are you going to say all HCFA-64 reports are inaccurate?
A No.
Q Well, which ones are you going to say are inaccurate?
A The one I listed here is a quarter ended December 31, 1994 -- is listed here.
Q And you're saying it's inaccurate?
A I'm saying it has some problems with it.
Q Okay. Well --
A In the report.
Q What are the problems with it?
A Or could have some problems with it.
Q Oh, could?
A Right.
Q You don't know?
A I don't know for sure.
Q So you would just be speculating, wouldn't you?
A I can give you -- I can talk about the documents that I've read that says those people in the Division of Medicaid -- that there could be errors in the HCFA-64.

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Q Are you going to say that that HCFA-64 is inaccurate?
A I'm going say I don't know whether it's accurate or not.
Q So you would be speculating?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Wouldn't you?
A I'm going to say I don't know whether it's right or not.
Q And what have you done to determine whether it's right or not?
A I know there are problems that was discussed in other documents that I read that would cause me to believe that that report could be wrong. I don't know.
Q Could be right, couldn't it?
A Absolutely.
Q Could understate the expenditures, couldn't it?
A Absolutely.
Q Who would be in the best position to determine whether or not that report was accurate or reasonable?
A I don't know who that person is.

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Q You don't know who that would be?
MS. SCHWARTZ: Objection.
A No.
BY MR. YOUNG:
Q Well, give me a wild guess as to who that might be.
A Someone within the Division of Medicaid.
MR. YOUNG: Off the record.
(Off Record)
BY MR. YOUNG:
Q We were discussing the HCFA-64s when we left. That was another example you gave me of, I guess -- is the HCFA-64 an internal control?
A No.
Q So that's not really an example of a historic and widespread internal control that's run amuck, in your opinion, is it?
A I think you were asking me what other areas that I may be talking about as far as payments were concerned.
Q Okay. I think we'll get to that. I thought we were limited to your opinions about historical widespread systematic problems with the claims processing and reporting. And we talked about the 30-day stay limit, the drug program. You

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gave me a few examples under the drug program, hospital rates, nursing home rates, gap package.
A I had mentioned widespread -- we were talking about widespread payments and how that affected the system, and I told you that those payments could affect the -- how the payments were characterized on the HCFA-64.
Q All right.
A As to which category that they were classified in.
Q All right.
A And I referred you to someone within the Division of Medicaid. And I guess I had specific reference to the testimony of Terry Childress that says that he wasn't aware, or couldn't -- didn't have any assurances that HCFA-64 was -- the expenditures were classified in the proper buckets, I believe is the word that he used.
Q Did you talk about that at lunch?
A No.
Q Okay. Did the -- any other historical or widespread systematic problems with the claims processing and reporting?
A Well, there were some other areas that I didn't mention. And we talked about the findings of

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the State Auditor being in the hospital rates and nursing home rates. There were other areas as to the proper payment of drug claims.
Q We talked about that.
A Huh?
Q We talked about that.
A I'm talking about -- we talked about that to the extent that that was referred to in another report. But I guess my reference now is to the dollar amount of -- they may sample a claim from ABC druggist down the street, and that claim was paid at $8 versus $9, whatever the State showed or vice versa. There were both overs and unders on that. And there was also, almost every year, the State Auditor's finding errors in payment of clinic and physician claims. I can recall one on the State Health Department, an error in a clinic reimbursement rate that resulted in a significant overpayment and underpayment. I, quite frankly, can't remember which way it was, but that's irrelevant as far as I'm concerned. There was a factor that was an error in that.
We had talked about the gap package, and you had asked that I identify those years in which the State Auditor had written a management letter to

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the Division of Medicaid. I believe that would be for -- I recall it being either five or six years that that same finding appeared in the recommendations of the State. I may be identifying as far as 1988 through 1993. The exact amounts for those years I, quite frankly, can't remember sitting here today. I don't have the numbers here today.

Q Anything else?

A Another report that indirectly affects payments has to do with whether the data that was used in setting the rates was audited data or not.

Q Were used in what rates?

A Used in setting nursing home rates -- whether that data was reliable or not. And specifically referring to two instances where this was of a concern to me as an auditor goes back to the 1984 PEER review of the organization where they had made recommendations that would, at least, appear reasonable to me as an auditor that they should have been auditing more of that data that was used to reimburse nursing homes. Apparently, there was very little auditing of the cost reports submitted by nursing homes to set their rates with.

I don't remember the exact year, but the State Auditor brought up a similar recommendation

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that must have been in the early '90s -- I don't know the exact year, late '80s -- where the Division of Medicaid wasn't following their own policy in the audits of the nursing homes. They had established a policy where X percent of the nursing homes would be audited, and they wasn't following that policy in auditing those facilities to ascertain that the cost claimed on those reports were reasonable or not.

Q Did you ever look to see the response of Medicaid with regard to these findings by the State Auditor?

A I did, and -- I did.

Q And?

A Their response, at least to the 1994 PEER report, that that was a decision that they made, and maybe they thought that it was adequate. But it was a recommendation that they expand the scope of those audits as well as the number of those.

Q Nevertheless, the State -- the Medicaid Division did respond to those findings?

A Insofar as the 1984 Peer Committee Report, they did. I don't -- I'm sure they responded because they must respond to findings of the State Auditor and them not following the auditing policies that they had established themselves.

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Q For what? For what issue?

A I don't know exactly the policy, but let's say the policy was to audit 25 percent of the cost reports each year.

Q For nursing homes?

A Right.

Q That's what we're talking about here?

A Right. And they wasn't following their own policy insofar as the numbers that they were auditing.

Q Did you look to see -- did you see the State's response to that?

A I'm sure I read it. I'll be quite frank with you. I forgot what their response was.

Q All right. Any other historical or widespread systematic problems with claims processing and reporting?

A I didn't make a detailed listing of what -- any of my intention during this review, but --

Q Well, that's what you're going to testify about, isn't it?

A -- sitting here today, those are the major ones that come to my recollection, and it may be others that come to my attention during the

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finishing up this review.

Q All right. I would appreciate it if you would let me know. All right. What historical widespread systematic problems concern third-party liability?

A Based --

Q The internal -- I'm sorry. The internal controls related to third-party liability?

A Based on documents that I've read, I don't think that the Department of Medicaid had a policy in effect to collect -- pursue third-party liability collections where a third party was the primary -- should have been the primary payor. It was discussions that they did adopt this policy in later years, but the system wasn't producing the reports. There were extended periods of time -- this is after First Health took over where they didn't bill third-party payors for their liability portion of the payment.

Q Do you know what third-party liability is in relation to the Medicaid program?

A I can give you an example of what I'm talking about.

Q I'm saying: Do you know what it is in relation to the Division of Medicaid in Mississippi,

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what the third-party liability program is?
A Generally speaking, I do.
Q Okay. What is it?
A They are supposed to pursue collections from those Medicaid recipients where a third party was liable for the -- for the payment.
Q What do you mean?
A Let's say a Medicaid patient had a car accident, for example, and they had a car insurance that should have paid for that hospitalization stay, but Medicaid -- the hospital is supposed to pursue collections from that insurance company before they bill Medicaid if they are aware of it.
Q And your opinion is that they didn't collect third-party liability monies?
A They didn't -- I don't believe -- my recollection is they didn't pursue that until the later years probably starting in 1991 or thereabouts.
Q 1991 was the first time the Division of Medicaid sought to collect third-party liability dollars?
A That's my recollection.
Q What are you basing that on?
A Out of some documents that I have read.

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Q What documents?
A I don't have -- I don't remember that document specifically.
Q You're just --
A I'm saying to you I believe that I read that in a document.
Q You believe you read it in a document?
A Right.
Q Do you know?
A My recollection is that I did read that in a document.
Q What document?
A I would have to go through the documents that I have. I didn't write that document number down.
Q So you're just drawing these conclusions without knowing what documents they are coming from, anything like that. You're just making these -- "I don't think they pursued third-party liability." Is that what you're doing, just drawing these conclusions like that?
MS. SCHWARTZ: Objection.
A I'm aware of the oath that I have taken.
BY MR. YOUNG:
Q Right.

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A And I'm telling you to the best of my knowledge and ability that that's what I read.
Q Well, when did the federal government require the states to pursue third-party collections?
A I don't know.
Q Do you know when Mississippi Medicaid put it in place?
A I'm not sure.
Q Do you know if it's reported on any reports?
A Yes.
Q What reports are those?
A It's netted against the expenditures by the Medicaid Commission.
Q And how long has the State been doing that?
A I don't know the exact date that they started.
Q Name for me one internal control related to third-party liability at the Division of Medicaid.
A I don't know whether you would refer to this as a internal control or not, but my experience as an auditor and my experience as a professional

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would dictate to me that if someone else is liable for a claim that you should pursue collection of that claim as opposed to paying it yourself.
MR. YOUNG: Would you read back my question, please.
(Record read)
MR. YOUNG:
Q And you didn't answer my question. Name for me internal controls related to third-party liability at the Division of Medicaid.
MS. SCHWARTZ: Objection.
A I don't know how you define internal control procedures as to whether -- insofar as third-party liability is concerned, but --
BY MR. YOUNG:
Q Well, how would you define it?
A I first would have to say that the Medicaid -- Division of Medicaid should be pursuing third-party liability recoveries if they weren't the primary payor.
Q Do you know whether or not the Division of Medicaid has a whole division related to third-party recoveries?
A I have read documents that say that they do have a division.

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Q Is that not a type of internal control?
A Not in my definition.
Q Okay. So the fact that they have a whole division related to pursuing the recovery of third-party liability, that's not an internal control, in your opinion?
A That doesn't fit my definition of internal control.
Q Well, what is your definition, then?
A It's policies and procedures in place. It's more definitive than saying that I've got a division to do that. It would be more specific.
Q Give me your definition of internal --
MS. SCHWARTZ: Why don't you let him finish his answer.
BY MR. YOUNG:
Q Give me your definition of internal control related to third-party liability.
A Have a policy in place whereby third-party liability claims are pursued for collections.
Q And your opinion is that the Mississippi Division of Medicaid has no such pursuit of third-party claims?
A I'm saying that they've failed in that collection of that.

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Q How?
A Based on documents I read, the reports weren't generated by the system that First Health was operating to permit them to properly pursue third-party liability coverage.
Q Do you know how third-party recoveries are even identified, Mr. Luckett, in the Division of Medicaid?
A I know how some of them are.
Q Do you know in the Division of Medicaid how they identify third-party recoveries?
A They identify them through claims that the providers filed in some cases.
Q Do you know whether or not Mississippi generated reports with regard to third-party liability recoveries?
A I know that there was discussions in the memorandum from Jan Larsen saying that they did not receive the reports from the First Health system to properly pursue third-party liability claims.
Q Any other internal -- widespread historic internal problems with third-party liability recoveries?
A I'm not aware of any others related to third-party liabilities at this time.

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Q Do you know how much the State recovered in third-party liabilities in 1996?
A No. I don't.
Q In '95?
A No, I don't.
Q '94?
A I don't know of any year exactly the dollar amount that they recovered or should have recovered.
Q Did you investigate to see how much?
A No.
Q Tell me the deficiencies in the design and operation of the -- any internal controls you're aware of related to eligibility. First of all, tell me how the ones at the Division of Medicaid are designed.
A Repeat that question, please.
Q How are the internal controls related to eligibility at the Division of Medicaid designed?
A I don't believe that they have a specific definition as to the internal controls of a system that they have as far as eligibility is concerned. I have relayed the fact that there were discussions and findings by personnel at the Division as well as the State Auditor. There were

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problems with eligibility, the fact that claims were scrambled and on and on and on.
Q All right. Now, that was just --
A Now, what caused those problems, I don't know.
Q Well, you're going -- your disclosure statement says you're going to talk about the design, the deficiency in the design and operation of the internal controls at the Division of Medicaid, Mr. Luckett. Now, if you don't know, then you tell me you don't know. But we're going to be here all night if you keep rambling on with answers that are nonresponsive.
MS. SCHWARTZ: Do you have a question?
MR. YOUNG: I most certainly do, and I'm prefacing it with that statement.
BY MR. YOUNG:
Q So if you don't know the design and operation of the internal controls, tell me that. Now, I'm going to ask you again: What were the deficiencies in the design and the operation of the internal controls for eligibility at the Division of Medicaid in Mississippi?
A I don't know the exact design of those systems. I can tell you that there were --

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Q That's my question. What was the design? And you don't know, do you?
A I can tell you that they weren't there and functioning as they should have been based on my experience as an auditor.
Q Mr. Luckett, you couldn't even tell me the name of one internal control that they had for -- on eligibility at the Division of Medicaid in Mississippi.
MS. SCHWARTZ: Are you speaking for the jury, or are you asking him a question?
BY MR. YOUNG:
Q Could you?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q You don't know, do you, sir?
A That's not true.
Q Well, then you tell me, by name, each and every internal control for eligibility.
A Internal controls do not have a name.
Q They most certainly do. At the Division of Medicaid they do.
A Well, I don't know the names that the Division of Medicaid has for each individual control.

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Q Well, then, if you don't know by the name, you identify for me, however you want to, each and every internal control that the Division of Medicaid had in place related to eligibility.
MS. SCHWARTZ: Objection.
A I don't know all that they had in place.
BY MR. YOUNG:
Q You don't know any of them, do you, Mr. Luckett?
MS. SCHWARTZ: Objection.
A I do know that they had significant problems. Based on the memorandum I had that apparently -- whatever controls they did have in place weren't functioning as they should have functioned.
BY MR. YOUNG:
Q You're going to talk about what controls were in place before you even get to whether they work or not, in your opinion. Now, I want you to identify for me what internal controls the Division of Medicaid had with regard to eligibility.
MS. SCHWARTZ: Objection.
A I don't know a listing of those.
BY MR. YOUNG:
Q You don't know them, do you?

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MS. SCHWARTZ: Objection. This is about the fifth time this question has been asked.
BY MR. YOUNG:
Q You don't know them, do you, Mr. Luckett?
A I don't know every control that they had.
Q You don't know any, do you, Mr. Luckett?
MS. SCHWARTZ: Objection.
A One control that they should have had, if they didn't have it --
BY MR. YOUNG:
Q Mr. Luckett, that's not my question, and I'm not going to have you sit here and ramble on on something that's nonresponsive.
Now, my question to you is: Name me the internal controls that you're aware of related to eligibility at the Division of Medicaid in Mississippi.
MS. SCHWARTZ: Objection.
A I don't have that listing.
BY MR. YOUNG:
Q You do not know them, do you?
MS. SCHWARTZ: Objection.
A I don't have that listing.
BY MR. YOUNG:
Q You do not know them, do you, Mr. Luckett?

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MS. SCHWARTZ: Objection. I think we're at number nine now.
A I don't have a listing of the internal controls at the Division of Medicaid.
BY MR. YOUNG:
Q I'm not asking for a listing.
A I don't know all the controls.
Q You don't know any of them, do you?
MS. SCHWARTZ: Objection.
A I would presume that one of the controls that they would have --
BY MR. YOUNG:
Q No.
A -- that it would issue duplicate cards that they --
Q Mr. Luckett, you are not --
MS. SCHWARTZ: You are interrupting him.
MR. YOUNG: No, I'm not.
BY MR. YOUNG:
Q You are not being -- you are not giving responsive answers. That's not my question. I'm not asking you to presume. I'm asking you: Do you know the internal controls related to eligibility at the Division of Medicaid in Mississippi?
MS. SCHWARTZ: Objection.

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A I don't know if they had any or not.
BY MR. YOUNG:
Q Now, for claims processing and reporting, identify for me, please, sir, the internal controls that were in place at the Division of Medicaid in Mississippi.
MS. SCHWARTZ: Objection. We went over this testimony before lunch. This same question was asked.
MR. YOUNG: I'd ask that you not make speaking objections.
MS. SCHWARTZ: Well, before you ask me -- every time I make an objection, you asked me what the basis is. So now I'm making it easier for you.
BY MR. YOUNG:
Q You can answer.
A Repeat your question, please.
MR. YOUNG: Read it back, please.
(Record read)
A I haven't reviewed their listing of internal controls that were in place at the Division. My experience as an auditor would dictate to me that one of the controls would be that only properly authorized claims would be paid at the specified proper amount.

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BY MR. YOUNG:
Q All right. Now, we're going to go in circles again, Mr. Luckett. My question is very simple. Identify for me, please, the internal controls at the Division of Medicaid in Mississippi concerning claims processing and reporting.
MS. SCHWARTZ: Objection.
A I don't know all the controls that they have.
BY MR. YOUNG:
Q You don't know any of them, do you, sir?
MS. SCHWARTZ: Objection.
A I can tell you what they should have had in place.
BY MR. YOUNG:
Q I want to know what they had in place.
A I don't know --
MS. SCHWARTZ: Objection.
A -- what they had, if any.
BY MR. YOUNG:
Q And finally, with regard to third-party liability, identify for me, please, sir, the internal controls that were in place at the Division of Medicaid in Mississippi related to third-party liability.

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MS. SCHWARTZ: Objection.
A I answered that question awhile ago. I told you I didn't know the internal controls that they had in place.
BY MR. YOUNG:
Q Do you have any formal training in information systems development?
A Information systems development being?
Q The development of an MMIS system, CPAS system, SURS system.
A I'm not -- I don't have any experience with the SURS or CPAS system, no.
Q MMIS system and the development?
A Not the Medicaid Management Information System, no.
Q Do you know what SURS is?
A No.
Q So you have no basis to state an opinion one way or the other as to whether or not Mississippi's Medicaid SURS system is an adequate reporting tool?
MS. SCHWARTZ: Objection.
A No.
BY MR. YOUNG:
Q In your review for your testimony in this

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case, did you review any of the federally required audits and reviews that were conducted of the Mississippi Medicaid program?
MS. SCHWARTZ: Objection.
A Are you talking about the Single Audit Act?
BY MR. YOUNG:
Q Any federal audits.
A I reviewed the Single Audit Act findings of the State Department of Audit. I read at least, if not in its entirety, some of the systems' performance reviews. But at this moment those are the ones that came to my mind that may be what you're talking about.
Q Do you know what federal audits are done of the Medicaid program?
A I know they have a review by HCFA with the Systems Performance Review Report.
Q Did you review those in connection with your testimony?
A I reviewed some of them.
Q Are you relying on any of those to form your opinions in this case?
A They had some recommendations for improvements in most of those.

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Q Do you know, at any time, whether or not the State of Mississippi's Medicaid Division failed to meet the federal regulations and guidelines?
MS. SCHWARTZ: Objection.
A Insofar as the systems' performance review is concerned?
BY MR. YOUNG:
Q In any areas.
A No.
Q With regard to systems' performance review?
A I think they received a passing grade for each year that was reviewed. I think it was a year -- at least one year that they failed to meet that review.
Q Do you know what the CPAS system is?
A No.
Q You're not going to offer opinions one way or the other as to the CPAS system or the reports generated -- or the reports generated from the CPAS system?
A Not --
MS. SCHWARTZ: Objection.
A Not unless it relates to some other form of testimony that we've already talked about.

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BY MR. YOUNG:
Q Well, do you know what CPAS is?
A No.
Q Have you met with any other experts --
A No.
Q -- on this case?
A Related to this matter you're talking about?
Q Yes.
A No.
Q Have you ever given testimony before other than at a deposition?
A It seems to me some years ago that I may have been involved in a certificate of need hearing with the public hearing before the State Board of Health, but that was a long time ago. Outside of that, I can't think of any.
Q Tell me about that again. What was that?
A I'm telling you to the best of my recollection that I was involved in a public hearing which had a hearing officer at the State Board of Health regarding a certificate of need. This goes back probably 15 years ago, if, in fact, it did happen. I know that one was scheduled and I believe that it took place.

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Q What was the certificate of need? What was that dealing with?
A Mississippi has in place a requirement for any capital expenditure exceeding $1 million in a new service that there's a couple of other maybe requirements for them to go before the State Board of Health to get authority to build that project or start that new service. Sometimes -- and they have a public comment that people can object to if they so desire.
Q What's the biggest hospital you ever audited?
MS. SCHWARTZ: Objection. What do you mean by "biggest"? Revenue, patients, square footage, number of doctors?
MR. YOUNG: I assume if it's the biggest with the number of doctors, then it would also be biggest in revenue. That might not be the case, though.
A North Mississippi.
MS. SCHWARTZ: Let him clarify.
BY MR. YOUNG:
Q In terms of revenue claims?
A North Mississippi Medical Center.
Q When did you do that?

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A I guess it was the last year that I was partner on that engagement would have been the September 30th, 1991, audit.
Q What were the type of revenues generated, roughly, by that hospital?
A Well, they owned several hospitals. They have hospitals, and my best recollection is -- I don't know how you want to -- what your definition of net revenues are, whether that's --
Q Gross revenues.
A Gross charges to patients? I would say it's -- and this is -- they probably would have been in the $300 million range.
Q Annually?
A Right.
Q How many claims did that comprise usually?
A Gosh, I have no earthly idea.
Q Any idea?
A Unh-unh.
Q When you audited North Mississippi Medical Center -- I'm assuming they passed the audit. Is that right?
A Is that a question?
Q Yeah. Is that right?
A They received an unqualified opinion on

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the financial statement.
Q What does that mean?
A That the auditor of Peat Marwick, in that instance -- in that case, felt that the financial statement presented fairly the results of operations and the financial position as of a given day and for a period of time.
Q Even though you gave them the unqualified opinion, I think is what you called it, did you still report certain findings and recommendations?
A I can't recall for that year whether we did or not, but that wouldn't have been unusual if we would have. I would suspect that we did report certain matters that came to our attention.
Q Errors perhaps?
A Recommendations for improvement.
Q Because of what?
A Our review of the internal controls and accounting procedures.
Q Some of the same type of-- generally type of things that we've been talking about here today with regard to Medicaid?
A That could have been some of those types.
Q And they still got an unqualified opinion?
MS. SCHWARTZ: Objection.

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A Sure.
BY MR. YOUNG:
Q Pardon me?
A Sure.
Q Well, how can that be?
A That opinion was -- I am not trying to not answer your question. That opinion was rendered based on the auditor's examination of those financial statements, and it was his opinion that those financial statements did present fairly, not precise, the results of operations. That could be items that would -- the auditor would bring to management's attention that wouldn't necessarily make the auditor have another opinion or type of opinion on those financial statements.
Q I still am not sure I understand. You can have findings and recommendations to correct certain things that you find during the audit procedure, but they still can get an unqualified opinion?
MS. SCHWARTZ: Objection.
A Absolutely.
BY MR. YOUNG:
Q And how is that?
MS. SCHWARTZ: Objection.
A That's -- the accounting literature

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permits one to do that.
BY MR. YOUNG:
Q For them to do what?
A To issue an unqualified opinion on the financial statement.
Q Even though there may be some problems with the internal controls?
MS. SCHWARTZ: Objection.
A True.
BY MR. YOUNG:
Q Pardon me?
A True.
Q The year that you were thinking that North Mississippi paid out 300 million or had $300 million worth of gross claims or revenue. Is that right?
A That's right.
Q What year would you think that was probably?
A September 30th, 1991, year end.
Q Do you know what Medicaid paid out or the total gross claims for Medicaid were in 1991?
A I know within a few hundred thousand dollars of that number.
Q Okay. Well, tell me.
A Probably $1 billion.

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Q How much?
A Maybe $1 billion.
Q Do you know how many claims they serviced?
A Medicaid?
Q Yeah --
A No, I don't.
Q -- on an annual basis. Any idea?
A No, I don't.
Q Okay. If you'll look at your disclosure statement again, please. Do you see where I'm directing your attention to?
A Tell me.
Q Last sentence on the first paragraph.
A Okay.
Q All right. You say, "He is further expected to testify that because of the unreliability and inadequacy of the State's controls, it is not possible to verify whether the State's Medicaid expenditures were properly made under the terms of the Medicaid program." Do you see that? "Or reflect reasonable payments for necessary medical care."
A Right.
Q All right. Now, I want to go at this. We have already talked about the unreliability and

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inadequacy -- your understanding of the State's controls. Okay. You say it's not possible to verify. What do you mean by verify?
A To be certain that the expenditures were properly made or for the proper purpose.
Q You mean be --
A To verify means to ascertain that they were proper.
Q To be precise?
A Right.
Q They could still be reasonable and not be precise. Is that right?
MS. SCHWARTZ: Objection.
A We don't -- what I -- I don't know what the numbers should have been, based on my review.
BY MR. YOUNG:
Q But you didn't audit them, did you?
A No.
Q When you audit someone, do you look for precision?
A No.
Q What do you look for?
A We look to see that those -- that they are reasonable and present fairly.
Q What state Medicaid expenditures are you

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referring to?
A The -- all of the payments under Medicaid.
Q Are you talking about the expenditures reported on the annual report?
A I'm talking about the medical expenditures, medical expenditures of the State Division of Medicaid.
Q Reported where?
A In their records.
Q In what records?
A Well, they are reported through -- in different formats from the records. They have a record of expenditures that were made within the program for the program.
Q Well, some of those records are adjusted. Some of them, you know, are claims data routinely gone back and adjusted for recoveries for overpayments. Which expenditures are you talking about? What set of expenditure data are you talking about?
A That could take the form of several different pieces of information, I would assume. The claims payments -- however you want to report them, I'm not concerned as to whether they're on Exhibit 1 of the financial statements or whatnot.

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I'm taking an overall assumption here or statement that I don't know whether those are right or not. Based on the documents that we have, we weren't able to verify the accuracy of those payments.
Q Did you go back -- did you look at the claims data tapes?
A No.
Q Why not?
A I didn't feel that I was -- had to look at that to draw what conclusions I drew.
Q You didn't want to actually look at the claims data and the expenditure data on the claims tapes?
MS. SCHWARTZ: Objection.
A I'm relying on reports that were furnished to me that were received, obtained from the Division of Medicaid, the State Audit Department, and -- I guess, as the two sources of most of the data that I have. Some of it came from some hospitals.
Q Well, is the claims data probably the best data to look at?
A Not for what purposes that I'm trying to draw a conclusion on, no.
Q Well, what purpose would you even want to look at the claims data then?

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MS. SCHWARTZ: Objection.
A I didn't do a detailed audit of those claims.
BY MR. YOUNG:
Q Oh, I understand that. I'm saying you're saying that the claims data tapes wouldn't be helpful at all?
MS. SCHWARTZ: Objection.
A If you wanted to verify the accuracy of every claim, then you would have to go back to those claims.
BY MR. YOUNG:
Q To the data tapes?
A Right. If you wanted to verify the accuracy of a particular claim.
Q You didn't do that?
A I didn't do that.
Q Okay. Did you attempt to verify the accuracy of the HCFA-64s?
A No.
Q Did you attempt to verify the accuracy of the annual reports?
A No.
Q Of the 2082s?
A No.

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Q How would you verify the accuracy of the State's Medicaid expenditures?
A I don't think my approach would be a lot different than what the State Auditor's approach was in any particular year in auditing the Division of Medicaid.
Q What do you mean in that sentence properly made?
A That the expenditures were made for the purpose for which the State intended for them to be made.
Q You said you would verify that no differently or attempt to do it no differently if you did it than if the State Auditor did it?
A If were you asking me if I were going to do a financial audit on the Division of Medicaid, I think my approach would have been very similar to what the State audit approach was.
Q In terms of making sure the expenditures were properly made?
A Right. Let me further clarify my approach insofar as the State audit is concerned. The difference that I would have had in this wasn't what the charge of the State audit was. They weren't charged with responsibility or with the -- they

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didn't intend to audit the records of the Division of Medicaid on a stand-alone basis. They didn't -- in the last 10 or 15 years, they never issued an opinion on the Division of Medicaid statements by its --
Q Do you know if anyone did?
A I don't know if anyone did.
Q Do you know if the -- do you know whether the Division of Medicaid did its own internal audit?
A I'm sure they had some internal auditors over there. That's commonplace for someone as large as they are.
Q Did you ask to see any of those reports?
A No.
Q Would those be important to your opinion?
A The reports that I received out of the Division of Medicaid, to me, were similar to the types of reports that I would expect internal auditors to make.
Q Did you ask to see any internal audits of the Division of Medicaid?
MS. SCHWARTZ: Objection.
A No, I haven't asked to see that.
BY MR. YOUNG:
Q How about third-party audits of Medicaid?

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MS. SCHWARTZ: Objection.
A I haven't seen any third-party audits of Medicaid.
BY MR. YOUNG:
Q Federal audits of Medicaid?
A Unless you call these system performance reviews audits, I haven't seen any.
Q You say, "under the terms properly made under the terms of the State's Medicaid program." What are the terms that you're referring to?
A The terms that I'm referring to there is the portions of the State plan that was described in the memoranda that I reviewed from sources such as the State Department of Audit and the State Division of Medicaid.
Q What are the terms?
A They are numerous terms. I can't tell you every term of the State plan.
Q Give me three.
A One of the terms would be that we pay on the claims according to the State plan. The State plan has a lengthy description as to the covered services they may have. I can't give you verbatim the --
Q Do the terms change from year to year?

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A Sure they do.
Q Did you go back and determine whether or not for any given year the payments were properly made?
A Only to the extent that that was discussed in memoranda that I received from the State audit of the Division of Medicaid.
Q You did no independent review --
A No.
Q -- to determine whether or not --
A No.
Q What do you mean by "reasonable payments"?
A That they approximate the amount that should have been paid. I didn't use the word "exact payments," but I would expect reasonable to be pretty close to the proper payment.
Q Do you mean in that context like $100 for an X ray?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Is that what you mean in terms of payments for necessary medical care?
A If that's a reasonable amount in accordance with the plan.
Q Well, who decides whether it's reasonable

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or not?
A That's a -- a lot of different people decide whether that's reasonable or not.
Q Well, how do you decide?
A It would be based on the claim that was filed. Every hospital doesn't have the same charge for different services.
Q So --
A So what's reasonable for one hospital may not be reasonable for another one.
Q Oh, I see. So that the reports that you've helped prepare for Delta -- the Delta hospital that you do consulting work -- that you said are reasonable to the Medicare or Medicaid Commission may be different than another hospital?
A I say it's reasonable according to what I understand the State plan is insofar as their cost report is concerned. It could be entirely different for Singing River Hospital in Pascagoula.
Q Well, did you go back and make a systematic determination of whether or not the payments that Medicaid made were reasonable in relation to what all these different hospitals charge?
A The payments would be dictated by the

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State plan.
Q And did you go back and determine that?
A That's not what we're referring to, I don't think.
Q Well, you tell me what you're referring to.
A That the payments were proper and in accordance with the State plan. The State plan doesn't necessarily say what reasonable payment for a particular service is. One hospital may be getting a per diem of $900 a day. The next hospital may be getting a per diem of $500 a day. Both of those would be reasonable payments for -- in accordance with the State plan.
Q Did you go back and try to determine whether or not the payments were reasonable?
MS. SCHWARTZ: Objection.
A Not --
BY MR. YOUNG:
Q You didn't, did you, Mr. Luckett?
A I didn't go back -- I didn't go back to each individual claim to determine whether that was a reasonable payment or not. I don't think that you -- I don't think the definition of a reasonable payment for a particular service, particularly in

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the hospital area is concerned that they do have maximum allowable charges for certain pharmaceuticals and DME supplies. But they don't have a fixed schedule as to what they will pay a hospital or a nursing home for a particular day of care.
Q Well, surely the payments submitted by the hospitals you do consulting work for to Medicaid were reasonable, weren't they?
A Absolutely.
Q And those payments by the Division of Medicaid to the hospitals, at least that you do consulting work for, are reasonable, aren't they?
MS. SCHWARTZ: Objection.
A Right.
BY MR. YOUNG:
Q But it's just all the other providers and hospitals that you don't work for that the Medicaid pay is unreasonable payments for?
A That's not what I -- I didn't say that.
Q Well, then what are you saying?
MS. SCHWARTZ: Objection.
A Tell me your question again.
BY MR. YOUNG:
Q I'm trying to figure out what your

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testimony is going to be. "The State's Medicaid expenditures were properly made -- it's not possible to verify whether the State's Medicaid expenditures were properly made under the terms of the State Medicaid program or reflect reasonable payments for necessary medical care."
A I'm telling you that I have documentation, and the documents that I reviewed that would lead me to believe there have been duplicate payments for services, that some of the rates may have been wrong, and we don't -- can't quantify the extent of those duplicate payments, payments at wrong rates or whatnot.
Q Well, did --
A I didn't go back and identify every -- I can't quantify. I'm not able today to quantify that.
Q Oh, I understand that. I understand that. Now, did Delta Regional Hospital that you consult for, did they get paid too much?
A I'm -- on Delta Regional, I submitted -- assisted them in submitting a cost report for the Division of Medicaid to process their hospital inpatient claims.
Q Did you ever bill Medicaid?

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MS. SCHWARTZ: Objection.
A I didn't compute the amount of the payment that the Division of Medicaid was to pay to Delta Regional Medical Center.
BY MR. YOUNG:
Q Do you stand by your report that you submitted?
MS. SCHWARTZ: Objection.
A They computed a rate from information that the hospital furnished them.
BY MR. YOUNG:
Q Did you review the report?
A I reviewed the cost report that was submitted by Delta Regional Medical Center.
Q In fact, you helped prepare it, didn't you?
MS. SCHWARTZ: Objection.
A I did.
BY MR. YOUNG:
Q Now, did you overbill Medicaid?
A The information --
MS. SCHWARTZ: Objection.
A -- that we sent to Medicaid was reasonable.
BY MR. YOUNG:

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Q In fact, Medicaid counts on hospitals, the very hospitals that you were auditing for 30 years, to submit reasonable statements for the Medicaid services they provide, don't they? Don't they, Mr. Luckett?
A They do do that. They do encourage that. But what I'm trying to tell you is that I told you earlier about a problem that the Medicaid Commission -- Division of Medicaid and First Health, maybe a combination, has in determining rates for hospitals is not necessarily the information that the hospital sends to them, but is extracting the information from that report that the hospital submits, and them computing what the rate may be.
Q I see. What about this statement for necessary medical care?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q What do you mean by that? You're not a clinician or a medical doctor, are you?
A No.
Q Okay. Well, what do you mean by "necessary medical care"?
A I'm telling you that it came to my attention that there were payment rates that were

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computed wrong, and those payment rates were used to pay medical care costs.
Q You're saying they paid for unnecessary medical care?
MS. SCHWARTZ: Objection.
A Do what, now?
BY MR. YOUNG:
Q Are you saying that the Division of Medicaid paid for unnecessary medical care?
A No, I'm not saying that.
MR. YOUNG: Off the record.
(Off Record)
BY MR. YOUNG:
Q We're back to your disclosure statement. When you said that -- whether the State's Medicaid expenditures -- last sentence -- were properly made under the terms of the State's Medicaid program or reflect reasonable payments for necessary medical care. The reasonable payments for necessary medical care -- how do you think that those costs should be determined?
A I'm not taking exception from the definition of reasonable costs as outlined in the State plan. The State plan should define what's reasonable cost or reasonable reimbursement for

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those services.
Q Sir, are you familiar with the Boren regulations on hospital or nursing home reimbursement?
A I have a general understanding of what Boren is. I could use some more education on that, if you want to tell me about it.
Q Do you have -- so you don't have a dispute with what the State plan says is necessary and reasonable?
A No.
Q You just don't believe --
A I don't believe the expenditures were made in accordance with the State plan.
Q And you base that on?
A The fact that we have got payments that weren't calculated according to the State plan. We've got other exceptions, eligibility and --
Q The things you pointed out earlier to me today?
A Right.
Q Is that right?
A Right.
Q Okay. How does an accountant measure the reliability of internal controls -- or an auditor, I

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should say?
A Either one.
Q Either one?
A He evaluates internal controls to see what strengths and weaknesses are in the system. This is a -- based on his training and expertise in auditing, he can form an opinion as to whether he thinks those controls are adequate or not adequate or where the weaknesses may be.
Q All right. I thought when we first started this morning, I asked you if you went into audit to do a financial audit of a hospital -- we were talking in terms of how many claims you would actually look at, and you told me, "Well, before I did that, I'd want to know a lot more things before I decided the number of claims." Do you recall talking about that?
MS. SCHWARTZ: Objection.
A Right.
BY MR. YOUNG:
Q I think you itemized that you would want to talk to the personnel there. Is that right?
A We would evaluate internal control strengths and weaknesses of a particular cycle that we may be auditing.

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Q So for that cycle, you would go in and you'd find out exactly what internal controls were in place?
A Uh-huh.
Q And you'd look at each one?
A Uh-huh.
Q And the strengths and weaknesses of each one?
A Right.
Q What else would you do when you're getting an idea of how you're going to set up your audit, I guess?
A Well, you would design your audit program to test those controls that you have identified and to make sure they were functioning in the way that you understood them to function.
Q But you'd have to first identify them. Right?
A Right.
Q Would you talk to personnel there?
A Right.
Q You would?
A Right.
Q Why would you talk to personnel there?
A To get an understanding of how the flow of

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the transactions were.
Q And you would do this -- this would all have to be done before you would ever give an unqualified opinion or reach some final conclusions. Isn't that right?
A On the financial audit, that's true.
Q What internal controls do you feel should be in place that, in your opinion, are missing from the Mississippi Medicaid program?
A I have relayed to you several instances where there have been an erroneous payment, be it either wrong dollar amount or whatever. And in my opinion, those controls should be either one, functioning or they should be perhaps controls that weren't in place that permitted these errors and irregularities to occur.
Q Well, my question to you is --
A I would have to know more about the system to give you a definitive definition of I would do ABC.
Q Oh, so you don't even know what you would do in terms of the Mississippi Medicaid program?
A I know I would try to strengthen the controls to not permit these errors that have been disclosed in these documents that I have reviewed

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from occurring.
Q I see.
A It may be --
Q And none of the hospitals you did ever had any of these kind of errors?
A Sure they did. Not the same error, but they would have errors.
Q But they would still, in many instances, get an unqualified opinion?
MS. SCHWARTZ: Objection.
A Sure.
BY MR. YOUNG:
Q Pardon me?
A Sure.
Q And when you say "unqualified opinion," that's another way of saying they passed the audit?
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Is that right in layman's terms because I don't --
A I'm not even --
Q What does "unqualified opinion" mean in layman's terms? "Layman" meaning nonaccountant or auditor?
A The CPA who audited those statements feels

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that the financial statements the management presents present fairly the financial -- the result of operations and the financial condition as of a particular date or period of time.

Q Is what?

A You have to understand that the financial statements are the responsibility of the entity in which you audit. The only thing that belongs to the CPA or the auditor is the opinion page that's attached to those financial statements. The rest of them are management's numbers. We don't prepare financial statements. CPA's don't prepare financial statements. They render an opinion as to whether they think those accompanied financial statements presented fairly the result of operations and financial condition as of a particular point in time.

Q Can I ask you something? And I think I got confused a little bit earlier. For instance, Delta Regional Hospital that you help prepare the cost reports, Medicaid and Medicare cost reports --

A Uh-huh.

Q -- that's submitted by the hospital to the Division of Medicaid in order to get reimbursed for the Medicaid expenditures.

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A I'm not trying not to answer your question. I want you to understand the purpose of that report.

Q Uh-huh.

A The purpose of that report is to submit to them the costs that the hospital says that they incurred for Medicaid inpatients for that year. It has nothing to do with outpatient claims. Medicaid doesn't pay them that cost as an exact amount. Medicaid uses that. The hospital submits its report to them. Medicaid takes the report and do whatever review they want to do on it. They take -- they extract some information from that report applicable to the Medicaid program of that hospital. They put that into a data sheet, and they go through a process of determining what the per diem cost will be for the State's next -- it used to be fiscal years. They have changed years on us now. But if I can try to oversimplify this for you. The State's on a June 30 year end.

Q Uh-huh.

A The cost report that Delta Regional Medical Center just sent in for their year ending 9/30/96 will be used to compute the hospital's per diem for the year -- well, they slid it back three

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months. It will be effective October 1 of 1997. They will pay that rate for 12 months. There's no provision for retroactive payment or not. That's the rate they are going to use.

Q Okay. So that's what they are paid for the treatment of Medicaid recipients at Delta Regional Medical Center?

A During the year for inpatients, now, they get a flat dollar amount, regardless of whether it's -- it may be a triple bypass or it may be a pneumonia case. They have an average daily rate that they pay them for the entire year, and it may be -- I won't get into all the exceptions to that. They can file for an exception for new services that come onstream during this period of time.

Q When does Medicaid actually give them the money?

A They pay them on each claim that they submit. They submit claims daily to them.

Q But they get a daily rate of whatever the person was in the hospital for?

A A person was in the hospital for ten days. It doesn't make any difference what the charges are insofar as what they are going to get paid for that patient at that moment in time.

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Q Right.

A He's in there for ten days. He's discharged, and hopefully within eight or nine days they send his claim in to First Health. ABC patient admitted May 1st, discharged May 11th, ten days. His total charges are $16,500. Now, if they have computed his rate to be based on these cost reports that were submitted, the average -- and they build in inflation factor -- the average to be $1,000 a day, they are going to get paid $10,000 probably within 30 days after they submit the claim. That's the end of the payment for that patient.

Q I see. So all the costs --

A He does go in the statistics to compute a prospective rate for the next cycle --

Q Okay.

A -- or the next year.

Q I see. So then it's important for the hospital, then, to keep a total or running total of what their Medicaid patients that they treat?

A Their activities as far as Medicaid inpatients are concerned.

Q Okay.

A Outpatients are reimbursed on another methodology.

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Q Okay. In your work with hospitals, insurance companies, either life or medical, have you ever looked at the -- any factors that cost the program money?
MS. SCHWARTZ: Objection. What program?
A What program are you talking about?
BY MR. YOUNG:
Q Any. Either the hospital program like where they are paying a predominant amount of claims for a certain reason. Do you see what I'm saying? Have you done any analysis work?
A I don't think so in any context that I could imagine you asking the question.
Q Have you ever looked at drinking or smoking as a cost to any program?
A No.
Q Okay. I see on your list that you've looked at the report of Dr. Miller.
A I perused that report. I think that's the report you're talking about. I believe the only thing that I did any work with in that report had to do with the claim for charity care.
Q Did you look at Dr. Max's or Dr. Oster's reports?
A No.

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Q So you're not going to be commenting upon their reports, are you?
A Not to my knowledge.
Q Do you know where Dr. Miller got his expenditure data?
A I would assume that the State submitted that to him. I don't know.
Q Do you know in what form?
A No. I have seen a schedule, I believe, at Singing River and Forrest General, and possibly even University. Outside of that report that shows they had had some charity --
Q Do hospitals make a -- in your experience in auditing hospitals, do the hospitals make a profit when they provide services to indigents?
MS. SCHWARTZ: Objection.
A I think you need to -- hospitals, most of the hospitals in the State have been making profits for the last several years. Most hospitals provide indigent care, if not all.
BY MR. YOUNG:
Q If they treated only indigent care, would they make a profit?
A "Indigent" being defined as those people who either will not or cannot pay for those

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services?
Q Right.
A No, they can't make a profit if they treat only indigent patients.
Q What is your definition of "uncompensated care"?
A Those services for which the hospital was not reimbursed.
Q Where do you get that?
A If you want to use the word "pay" as opposed to "reimbursed," that will be fine too.
Q Is that expressed in charges or costs?
A It would be expressed in costs insofar as I'm concerned.
Q Where did you get that definition?
A I guess being an accountant.
Q Okay. That comes from just general accounting principles?
A General knowledge.
Q Okay. What is your definition of "charity care"?
A I think the book definition of that -- and a lot of hospitals, and even a lot of us have different opinions on this, but charity care, I think, is that care that you render to individuals

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whereupon admission of that individual or soon thereafter you make a determination as to -- that you're not going to pursue collections of the account. You make the determination that this person is medically indigent, and you really don't even try to attempt to collect from that patient.
Q How does that --
A Now, there are certain levels of charity care. Now, they may say that you can afford to pay 25 percent of this bill or whatnot. But most hospitals have a -- some guidelines in determining the poverty level or medically indigent level that they apply to. That decision doesn't necessarily have to be made upon admission for treatment of that patient. Some hospitals will not evaluate that patient to meet that criteria until after discharge even.
Q And what is the difference between uncompensated care and charity care?
A To me there's not any difference. Both of them are services that the hospital performs for which they are not paid for those services by those patients involved.
Q In your opinion, there is no difference?
A Not a great deal of difference.

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Q Are they separated on any accounting statement at the hospital?
A Right.
Q They are?
A Right.
Q Why do they separate them?
A Charity care, because of the definition that I gave you for that, that they don't pursue collections, they make a determination and they are not even going to pursue collections of those. While those charges are reflected in the books or the general records of the hospital, insofar as the financial presentation of them, they are deducted out of gross charges and not even reflected on the statement of revenues and expenses. That amount should be disclosed in the footnotes of those financial statements, but they --
Q And that's reflected in terms of charges?
A Right.
Q Not costs?
A The disclosure in the footnote is reflected in terms of charges.
Q And uncompensated care?
A When you say "uncompensated care," I assume you're talking about bad debts.

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Q I'm assuming whatever definition you gave it. You told me in your opinion --
A I'm trying to say --
Q Let me finish. You told me in your opinion they are sort of the same. But, yet, they are segregated on the financial statements. Is that right?
A Right.
Q So where would I find uncompensated care on the financial statement?
A Uncompensated care, excluding charity, would be reflected as bad debts.
Q Including charity?
A I said no charity would be included in the bad debts.
Q Okay. So it would be in the bad debts section?
A Right.
Q Okay. And that's referred to in terms of costs or charges?
A That's reported as charges.
Q Both of the charity care and uncompensated care are reported as charges?
A Insofar as the financial statements are concerned.

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Q Why?
A I think that's to have some uniformity in reporting. Obviously, each hospital is going to have different costs as it relates to both charity and bad debts. To have some uniformity in reporting, as opposed to reporting costs, they report the charges.
Q You've actually -- when I say "you" -- well, you may have actually done it. Peat Marwick has actually prepared or audited financial statements where this very segregation between uncompensated and charity care has been done at various hospitals, haven't you?
A There was a new disclosure requirement coming out insofar as charities are concerned before I quit the practice of accounting. I don't know the exact year, but it was a new requirement that it be netted against gross charges and shown as charges in footnotes to the financial statements.
Q Okay. I don't think that was my question. My question was: Peat Marwick has actually helped prepare financial statements and audited financial statements where both uncompensated and charity care were segregated for these charity -- for hospitals, haven't they?

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A I wouldn't say they -- they have audited financial statements where these disclosures were made, but they didn't prepare financial statements.
Q Okay. In fact, they have audited those financial reports for Singing River Hospital.
A That's true.
Q Did you do any of that for UMMC?
MS. SCHWARTZ: Meaning him or Peat Marwick?
BY MR. YOUNG:
Q Peat Marwick.
A I don't have any idea.
Q In the early '70s?
A I don't think so.
Q Okay.
A I'm certain that they didn't because they -- Peat Marwick has never performed a financial audit of University Medical Center.
Q Okay. Do -- does GAAP or Generally Accepted Accounting Principles address how hospitals should calculate uncompensated care?
A No.
Q Okay. Are there any published sources on which you or other accountants rely which tell them how to define uncompensated care?

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A I think that's Accounting 101 that, you know, bad debts are bad debts. It's an amount you didn't collect, the charges you didn't collect from those patients after an effort to collect those. And they have to be charged off.

Q Under what circumstances would you conclude that a hospital had no uncompensated care?

A There are -- there have been -- there are instances where hospitals have had their uncompensated care reduced for funds that they received for that purpose. And I can talk you back -- let me give you an example of that. I think if you want to single out your Singing River, some several years ago the -- I'm not -- maybe I shouldn't use Pascagoula. Let me use a county or where the county board of supervisors --

Q Okay. Before you go on with that, you realize my question said "no uncompensated care." I realize you qualified that by saying "some of their uncompensated care." I'm asking what circumstances can you think of where a hospital would have no uncompensated care?

A I never have seen one where they didn't have any, but they could.

Q Okay. So your answer to my question is

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none.

A I haven't personally seen that.

Q Where there's been no uncompensated care?

A Right.

Q Okay. What about charity care?

A The same thing.

Q Never seen an instance where a hospital --

A Since the accounting literature identified or made it -- I shouldn't use the word "mandatory," but recommended disclosure from charity care --

Q You've not seen an instance where a hospital had no charity care?

A Charity care was only identified as such probably six, seven, eight years ago.

Q You've not seen --

A Otherwise it was just included in bad debts.

Q Okay. So previous to that, then, it was included in uncompensated care?

A Right. Or bad debts.

Q Okay. After that when you did segregate it in its own category, you still have not seen an instance where a hospital --

A No.

Q -- let me finish. Where a hospital did

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not provide -- did not provide charity care?

A That's true.

Q It's been your experience that there's always charity care provided?

A Right.

Q I knew I would get it one of the ways. All right. I want you to look at your disclosure statement for me again. In the second paragraph on your disclosure statement, I'm assuming this was prepared -- you said, "Plaintiff has not described in any detail the basis for the damages relating to that claim, i.e. the uncompensated care claim." I now assume that you've seen the claim.

A Right.

Q So that's sort of like null and void now. Right? That section of your disclosure statement?

A When this was prepared, I don't think that the State had presented any detailed computations to -- as to how they -- what amount they were seeking insofar as the financial statement.

Q Okay. What I am getting around to, you've seen enough now to make your opinion?

A Right.

Q Okay.

A Well, I'm going to qualify that when you

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get into your questions; but, yes, I've seen the beginning of that. And, I think, what you said that sentence is null and void now.

Q Okay. So you can't render an opinion as we sit here today what you're going to say about uncompensated care?

A Right.

Q Okay. But you've only reviewed Dr. Miller's report. Is that right?

A I saw the damage claim form where I believe you've got some -- a schedule there that I prepared.

Q Okay. I'm going to ask you about that.

A Right.

Q That came from Dr. Miller's report?

A I believe that that was the title of that one.

Q Okay. Let's go ahead and get you to identify this for me, then. You did make notes on something.

A And I gave them to you.

MR. YOUNG: If you'll mark that for me, please.

(Exhibit 6 marked)

BY MR. YOUNG:

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Q Mr. Luckett, I'm going to hand you what's been marked as Exhibit 6. Could you identify that for me, please.
A This is a work paper that I prepared from two or three different sources. The total charges are for request for --
Q Before we get into the particulars -- I'm sorry to interrupt; but before we get into the particulars of it, is it two different -- I may have handed him --
A It is two different ones.
MR. YOUNG: Let's go ahead and get this one marked. I thought it was all stapled together. Is it marked? No, we need to mark this one too.
(Exhibit 7 marked)
BY MR. YOUNG:
Q All right. Right now you have got Exhibit 6. Can you read me the title of that in case someone can't read your handwriting?
A University Hospital Ratio of Costs and Charges. And I have several columns that's headed.
Q Okay. Go ahead and why don't you read to me the column headings.
A The first column would be the year. The second column would be charges. The third column is

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cost. The fourth column is cost ratio.
Q All right. Now, and you prepared that. Correct?
A I did.
Q What were the sources that you used in order to prepare that particular document?
A The sources really were two. The column that's headed Total Charges Per Request for Damages, those numbers were lifted from the -- what's the name?
Q Dr. Miller's report?
A Right.
Q Okay.
A And those were only yearly totals of charges for that report -- along with the year were lifted from his report. The second and third columns were numbers that I lifted from the cost reports from various years, and maybe a couple of years I used the financial statements for some entities to come up with a ratio of cost to charge. That ratio is nothing more than the cost that I lifted from that cost report divided by the charges that I lifted from those cost reports or the documents that I referred to in my ledger.
Q What cost reports?

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A For example, this first sheet is for University Hospital.
Q First column or first sheet?
A The first sheet.
Q Okay. Can I see that? I don't have another copy of it, so we're going to have to sort of talk about it together.
MS. SCHWARTZ: Do you want to sit here so you can --
MR. YOUNG: We probably can do it like this.
A This is University Hospital. This is Forrest General. This it Forrest General, and this is Singing River. You only had one, two, three, four five years in there for Forrest General with any charges reflected in that report.
BY MR. YOUNG:
Q Okay.
A And for Singing River, you only had three years of charges reflected in that.
Q Okay. The cost report coming from Vince Miller's?
A No. These were cost reports that were submitted to me by the law firm as documents.
Q Okay. From the individual hospitals?

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A I don't know who -- did we get these?
Q I mean, are these Medicaid documents that you pulled the numbers from?
A They are the combined Medicare/Medicaid cost reports.
Q That were prepared by the hospitals?
A In some situations those were the original hospital reports prepared by them. I guess all of them were. Some of them were cost reports that had been audited by the Medicare fiscal intermediary.
MS. SCHWARTZ: These were documents produced either by the State or the hospitals in this litigation.
MR. YOUNG: All right. I'm just trying to figure out if I wanted to go back and reconstruct this, where I turn to reconstruct it.
MS. SCHWARTZ: Take a look at the index and see.
BY MR. YOUNG:
Q I tell what you, Mr. Luckett, in order to get done today, would you do me a favor and counsel provide me the source. Identify -- I'm not saying copy me with the document actually, but the source with the Bates number that went into making that up.
MS. SCHWARTZ: We can do that.

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MR. YOUNG: Okay. I just want to be able to go back if I wanted to go back and prepare my own charts, I could do it.

A I think this legend here is going to tell me what I looked at. This 1 by this 1977, for example, information obtained from audit of Medicaid cost report, review of cost of charge work sheet.

BY MR. YOUNG:

Q Right. I understand, but it --

MS. SCHWARTZ: It's probably this document here. But you just want us to --

MR. YOUNG: To go back and verify and give me the Bates number, and I'll go back and -- that's all I need. Okay. So you're going to do that for me?

MS. SCHWARTZ: I'll make a representation, but we'll do that.

MR. YOUNG: Okay. Great.

BY MR. YOUNG:

Q Okay. Any other documents besides the cost report that you can think of that went into making up Exhibit 6?

A I believe some of them would be reference to the annual financial statements.

Q Okay. Anything else?

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A Not that I can think of.

Q Okay. I'm going to hand you what has been marked as Exhibit 7. If you can, read me the title of that.

A A Summary of Medicaid DHS Payments For -- and in parens Taken from Letters from Medicaid to Providers, closed paren.

Q Okay. Did you prepare that --

A I did.

Q -- document?

MR. YOUNG: Again, we'd ask if he could identify the materials that went into making up that a Bates number so we can pull those.

MS. SCHWARTZ: Sure.

BY MR. YOUNG:

Q When you say "Summary of Medicaid DSH," that's referring to DSH payments. Is that right?

A Right.

Q Okay. We'll get into a discussion about that in a few minutes. You probably need to refer to these. I'm going to give those to you anyway. If you could, tell me what conclusions you have reached regarding the uncompensated care dollars. And I'm assuming if you want to segregate between uncompensated care and charity care for this

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purposes of this question, you tell me. Otherwise, I will consider them both merged. What -- the conclusions you reached regarding uncompensated care dollars used in the damage analysis, for instance, first for the University of Mississippi Medical Center.

A It's my understanding that the amounts reflected in the damage suit for University Hospital, as well as the other two hospitals involved, is requesting reimbursement for that pro rata share of it based on charges of those facilities that were classified in their definition as uncompensated care.

Q All right.

A Charges are not costs.

Q Right.

A Charges represent something other than cost.

Q Right.

A This was a first cut, and I want to reemphasize "first cut," because to really -- to get the more accurate estimation of what costs are, I would need additional information, which wasn't available to me when I did this.

I went back to the cost reports to try to

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determine what the ratio of cost to charges were to develop a percent to apply to the charges that they had claimed.

Q I got you. So are you looking for any additional documents?

A Well, in order -- quite frankly, the -- and I labeled that column there Estimated Cost because it really is an estimate of those costs. Quite frankly, I believe that that estimated cost is on the high side. The reason that I think that is --

Q For all three hospitals?

A Right.

Q Okay.

A The reason that I think that is in order to better refine that estimated cost, I would need to know a breakdown between inpatient and outpatient of those charges. Generally speaking, outpatient charges, on an average, have a lower cost per dollar of charge than would an inpatient.

Q Right.

A The second thing that would make that estimated cost, in my judgment, a little bit higher is these may be balances of accounts written off as opposed to the full charge of that account written

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off. In other words, they may have collected some amount against the original bill, and it may be some profit in that amount that they collected which hasn't been accounted for in my calculation.

Q Okay. Have you requested additional -- are you finished? I'm sorry.

A I have not reduced any of these estimated uncompensated costs for what I believe is partially, if not all, recovered through the disproportionate share of payments. I think with these three qualifications -- those would be, as I recall right now, my three qualifications against my estimated cost here.

Q Okay. So you --

A One other one, I'm sorry, comes to my mind.

Q Okay.

A On the Singing River, we did have a question -- I did have a question on the amounts that were reported by Singing River. They had two or three line items. I can't recall two of them, but one of them they labeled "Other." I didn't know what other was. I'm kind of led to believe that that amount shouldn't be in a claim for bad debts and charity. I don't think it related to patient

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care.

Q Okay.

A That's one other qualification that I have on my record.

MS. SCHWARTZ: For the record, I believe that the hospital representatives were deposed last week, and I think the attorney who deposed them did ask for additional documents as a result of that deposition.

MR. YOUNG: I understand his qualifications.

BY MR. YOUNG:

Q Why did you prepare this cost to charge ratio sheet?

A To get a first cut as to what the -- as opposed to a claim for charges, that cost is certainly something different from charges.

Q Who told you that was important?

A Nobody had to tell me that was important, that the claim is for charges as opposed to costs, and it was my general understanding that the claim was for costs and this is not costs.

Q Where did you get that general understanding from?

A As to the claim was for costs?

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Q Uh-huh.

A In my conversations with the attorneys representing their client.

Q Who?

A Who told me that?

Q Yes.

A In conversations with John Hay and Jordana.

Q Counsel for the tobacco company?

A Right.

Q Okay. So that's why you prepared this cost to charge sheet?

A To begin the calculation of what costs may be.

Q I understand. Do you know if Peat Marwick audited Singing River from '93 to '95?

A I believe that they did.

Q Would you have any reason to dispute their audit findings?

A No.

Q Or the findings?

A I haven't seen the findings, I don't believe.

Q If Peat Marwick found that the financial statements were in order, would you have any reason

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to disagree with them?

A No.

Q Is this in the column on Exhibit 6, Total --

A Charges Per Request for Damages.

Q Is that $5.17?

A That's 5 million, one hundred seventy million -- I mean, 170,000.

Q So -- and the cost on -- as opposed to the charge in that particular instance did not --

A It would be 4,000,084 -- 4,000,845. This was the way it was expressed in the damage suit. These are the millions right here, 5.17 million.

Q Okay. Where did you get this cost to charge ratio?

A This is nothing more than a division of the cost by charges. In other words, column 3 divided by column 2.

Q Okay. How come the cost to charge ratio seemed to narrow -- actually it increased?

A Cost to charge ratio decreased.

Q Decreased?

A Right.

Q Here it's almost a one-for-one match between cost and charges. Or am I reading that

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improperly?
A This number is a product of 93.63 percent of this number.
Q Correct. So it's almost a one-for-one match. In other words, my reading, for instance, in 1971 there was very little difference between the cost and charges?
A Right.
Q Right?
A Right.
Q However, as we go down to 1992, for instance, there's a bigger discrepancy between cost and charges?
A There's a bigger difference between cost and charges.
Q And why is that?
A I can only tell you.
Q Okay. You don't have an opinion about that?
A I can tell you most probably why that's like that.
Q All right.
A University of Mississippi was receiving -- and I'm guessing to a certain extent that the legislature was probably funding more of their

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operations through the State appropriations than they have in the last several years.
Another factor that came in is University of Mississippi Hospital is managed, as I understand it, by Quorum, an outside group, and they have input into the charter structure out there. I don't know the exact year that they began, but them having a -- more of a structured approach, for lack of a better word, in establishing charges, they probably felt that it was time to try to establish the charge structure so that the hospital wouldn't have to depend on State appropriations.
Q Okay. I take it, then, that you don't have, necessarily, an opinion as to the uncompensated care dollars reported by the hospital on their financial statements as to the accuracy of those figures one way or the other?
A No. I took those directly from what where -- the charges that were included on that damage claim suit.
Q So you --
A I haven't taken exception with the amount that they reported.
Q And do you plan to do that?
A Not as I sit here today, I don't.

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Q Okay.
MS. SCHWARTZ: Just so I understand, you're saying if they -- if University Hospital said they had $10 in uncompensated care in one year, are you saying is he going to dispute that it should have been 8? Is that what you're getting at?
MR. YOUNG: No. If their financial statement says they reported $10 in uncompensated care, is he going to challenge the accuracy of the $10 that they reported?
A Now, they may be reporting gross charges.
BY MR. YOUNG:
Q Charges versus cost?
A Right.
Q I understand that. I understand that you're going to dispute what the actual cost is to the hospital --
A Right.
Q -- or what they can recover.
A Right.
Q But, I mean, that's for debate for a later date. All right. Have you prepared any other -- besides documents 6 and 7 -- any other summaries or charts?
A No.

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Q Okay. Do you plan to?
A I am not aware of any right now.
Q Okay. How do you define "contractual adjustments"?
A Contractual adjustments is a difference between the established charges of the hospital minus reimbursement from third-party payors.
Q One more time.
A Contractual adjustments is the difference between the established charged rate of a hospital less reimbursement that they receive for those services.
Q Okay. Would you include dollars for contractual adjustments in uncompensated care dollars?
A No.
Q Why?
A Because most contractual adjustments result from an arm's length transaction between the hospital and the third-party payor. They agreed to a price that they will accept for those services, and whether they make a profit or loss on that, it's an arm's length transaction. And they may lose money on one and make money on another one, so it's a business decision that they made. It has nothing

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to do with the ability of that third party to pay or not to pay.
Q But if the hospital routinely accepted less, why wouldn't that factor in on your uncompensated care dollars?
A I would certainly hope that they wouldn't agree to accept less than cost. That wouldn't be a good business decision for that hospital to make.
Q Explain that, please.
A If you were operating a hospital, why would you agree for someone to pay you less than cost unless it was a strict charity patient where you knew up front that you were going to forgive him for his debt?
Q Do you know how disproportionate share hospitals are identified in the State of Mississippi?
A I have a general understanding of that.
Q And what's your understanding of that?
A The definition of disproportionate share has changed some two or three times since this program began.
Q When did it begin?
A I believe in Mississippi it was 1991. In 1991, the first cut that disproportionate share was

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those hospitals who served more than a specified average Medicaid population -- I'll try to take you through an example of the way they were determined in the first year of the program if you would like me to.
Q Well, I just want to know do you have a -- do you know how they are identified?
A Right.
Q Generally?
A Generally, I do.
Q Okay. Tell me.
A Well, in that first year, they selected hospitals who had Medicaid utilization of at least 125 percent of the State average Medicaid utilization. That was the first year. Sometimes after then it's been changed to maybe not 125, but some other percent of Medicaid utilization. I think the most current definition of disproportionate share hospitals -- there are certain criteria they have to have more than 1 percent Medicaid. One of the other criteria is they have to have 75 percent of the State average. Uncompensated care is included in that determination of disproportionate share hospitals.
Q What is the purpose of the

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disproportionate share hospital payments?
A To reimburse the hospitals for uncompensated care.
Q Those payments are made by the Division of Medicaid?
A They are.
Q And that program -- let's call it DSH.
A Right.
Q The DSH program didn't come in until 1991. Is that right?
A That's my recollection.
Q And at that point, it still wasn't available to all the hospitals in the State of Mississippi.
A It was available to those that qualified.
Q Okay. Prior to that, were the hospitals facing an inordinate amount of care that they didn't get compensated for?
A Inordinate is a inconcise word. They -- all hospitals have a significant amount of uncompensated care. Maybe significant is a loose word too, but nothing has happened over the last 20 years that would make that ratio -- in my judgment, to make the ratio of uncompensated care increase significantly over 20 years ago.

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Q Are you telling me that from 1973 to 1990, for instance, the amount of indigent or uncompensated care provided by hospitals around the State did not increase tremendously?
A Not as a percent of the total.
Q What do you mean "not as a percent of the total"?
A Well, if they were running 6 percent uncompensated care in 1973, I don't -- I'm of the opinion that that uncompensated care is probably still 6 percent in 1993.
Q But the totals increased?
A Absolutely.
Q So the dollars would have increased. Just their ratio of how many indigents they treated at their hospital may not have necessarily --
A Ratio of total dollars.
Q Expenditures --
A Right.
Q -- would have increased. Is that right?
A The ratio would, in my judgment, remain about the same.
Q But the monies being spent on indigent care --
A The absolute dollars.

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Q -- would have increased?
A The absolute dollars would. Right.
Q Which would have put a bigger burden on the hospital. Is that right?
A Percentagewise it wouldn't put a bigger burden on them.
Q Actual dollarwise? Wouldn't it?
A I think the level of the burden would be the same. I'm not trying to dispute what you're saying. I think the level of the burden would be approximately the same. The absolute dollars increased.
Q Let me ask you this: Now, we have uncompensated care dollars that you've itemized on Exhibit 6 for University Hospital dating all the way back to 1970, for instance. Do you see that?
A Those were numbers that I extracted for uncompensated care out of this damage report.
Q Okay.
A Right. I see.
Q So that spans a period of about 20 years, something of that nature. Twenty-seven years, actually.
A Well, I believe it's 30 they projected.
Q Up to the year 2000.

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A Right.
Q Okay. Let's look over at Singing River Hospital. We have uncompensated care reported for three years.
A That's right.
Q Now, Singing River was providing uncompensated care or charity care for many years other than that, weren't they?
A Right.
Q So to the extent that those figures aren't available, that would be money uncollected in this particular instance. Isn't that right?
A Those figures, I presume, are available. These were the amounts that was reflected in the claim. They either chose not to submit claims for other years -- or I don't know why they didn't. I don't know who requested that information from them.
Q But as an auditor of Singing River hospital, you know --
A Right.
Q -- that there was a certain amount of charity and uncompensated care for Singing River that is not reflected in this particular summary?
A Sure it is. Sure it is.
Q That's gone unsought by the State of

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Mississippi --
A That's right.
Q -- in this particular case. Isn't that right?
A I believe that to be true.
Q And it's probably a substantial amount of money, isn't it?
MS. SCHWARTZ: Objection.
A I don't know what that number would be.
BY MR. YOUNG:
Q Well, you audited them.
A I still don't know what the number would be, but I would think that it would be, you know, proportionately the number that they requested -- identified or included in their claim for the three years that they submitted that information.
Q So to the extent the State is only seeking to recover a portion of the uncompensated care for these three years, in all likelihood, is a conservative amount of the total uncompensated care or charity care provided by Singing River over many years.
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Isn't that true?

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MS. SCHWARTZ: Objection.
A I don't have an opinion on that. I was only trying to, to the high side, estimate the costs applicable to those amounts that were reflected in this damage claim.
BY MR. YOUNG:
Q Well, to the extent other years that you know about are unreported on here that this figure would be small to the extent those other payments for uncompensated and charity care are not reflected.
MS. SCHWARTZ: Objection.
BY MR. YOUNG:
Q Isn't that right?
A I don't know that for a fact. I would make the assumption that it would, but I haven't seen the numbers, quite frankly.
Q But all you know is that --
A This is what they asked. This is what was included.
Q And that Singing River did provide uncompensated and charity care for years other than this?
A I'm sure they did.
Q Well, did you audit them?

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A I didn't audit them -- I didn't audit for that particular number in those financial statements where I was on that engagement, no.
Q Okay. What about for Forrest General Hospital?
A I think the same would apply there.
Q That for other years not present on here, they likely provided uncompensated and charity care?
MS. SCHWARTZ: Objection.
A They probably did. I don't know that for a fact.
BY MR. YOUNG:
Q Again, what is the purpose of the DSH payments by Medicaid?
A To reimburse the hospital for uncompensated care.
Q Why?
A That's what the law says. I didn't write the law.
Q Do you know why the law was passed?
A To reimburse those hospitals that were serving a disproportionate share of low income people. And they passed this law to reimburse those who met the criteria for the uncompensated care.
Q How are the DSH payments calculated for

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each of the three hospitals included in the damage claim?
A It's their relative percent of that total uncompensated care to the pool of the hospitals in the disproportionate share pool.
Q Okay. Are contracted adjustments part of this calculation?
A It could be that a portion of Medicaid contractual adjustments is included in this calculation. I believe these instructions --
Q Do you know?
A Huh?
Q Do you know one way or the other?
A No. It would depend on the individual hospital. As I understand the instructions, they were told to come up with total uncompensated care which could include any shortfall that they may have received from the Medicare program in providing services to those Medicaid patients. If I said Medicare program, I meant Medicaid program.
I take you back. Let me tell you -- I don't expect you to have followed everything I said, but I take you back to the per diem that I told you that Medicaid computed from the cost report that is submitted. Based on this cost that was submitted,

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they determine a per diem. They build in certain inflation factors and trend factors and this type thing trying to project it out for -- quite frankly, it's over probably a two-year period of time. To the extent that these projected payments fall short of reimbursement for that cost for that year during which these payments are made, it's my understanding that they can take that short fall and include it as uncompensated care.
Q Do the -- Medicaid pays DSH payments to these hospitals in order to help compensate them for providing indigent care?
A To compensate them for providing uncompensated care.
Q Or indigent care?
A Right.
Q Okay. Do the hospitals have to pay in order to receive DSH payments?
A There is an intergovernmental transfer of funds from these hospitals to a fund -- is my understanding that was created by the legislature called the Medical Care Fund. The monies are transferred from the hospitals to this fund.
Q So is the true uncompensated care the net amount between what the hospital receives or the

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uncompensated care claim less the DSH payments?
MS. SCHWARTZ: Objection.
A The amount of the transfer from the hospital is made to this medical care fund. These monies are then used by the State in matching funds for the hospital. It's my general understanding that these are -- while the hospital does receive DSH payments, these two transactions are separate. There is no guarantee from the Division of Medicaid, as I understand it, that a hospital who transfers funds to this medical education fund will ever receive that money back. It goes into the -- just like a State general appropriations fund for the Medicaid program. The amount of the transfer back to the hospital -- the DSH payment back to the hospital is a separate computation where --
Q You're talking about the actual transfer from Medicaid to the hospital?
A Right. It's a separate computation, and there are limitations on this amount that they can receive as DSH payments. Now, at one time it was 200 percent of cost. And there's another limitation subject to funds available to pay these.
Q Right.
A So it's a catch-22. They receive this as

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a separate reimbursement, and this reimbursement is based largely in part on the amount of uncompensated care that the hospital reflects on this form or questionnaire that they fill out to determine their eligibility for DSH payments.

Q Okay. So it's a separate payment. Medicaid simply pays these hospitals DSH money to help them to provide indigent care.

A Right.

Q And that's it? I meant that's the extent of the payment?

A It reimburses them for their uncompensated care.

Q Does it always totally reimburse them for all the uncompensated care that they provide? I guess my question, Mr. Luckett, is: Why would they still carry an uncompensated care column on their ledger sheet if DSH totally took care of that?

A I think that they are probably doing that because none of that money has been netted against this uncompensated care on their financial statements, as I understand it.

Q On what?

A Take University, for example.

Q Right.

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A They received --

Q We're going to Exhibit 7.

A -- for June 30, '96 year -- they have a June 30 year end. Based on what I saw, they received $49,933,206 in DSH payments for that year.

Q Right.

A Now, they have not reduced uncompensated care for any of that, is my understanding.

Q Where do you get that understanding from?

A From the fact that I saw a schedule that they had prepared and that number -- a portion of that number was netted against uncompensated care.

Q Should it be netted against uncompensated care?

A In my judgment it should be.

Q Why?

A Because that's the -- by definition, the DSH is to reimburse the hospitals for uncompensated care. That's the way that number is determined, and that's what I understand the law to say, that this is a program to help those who have a high proportion of uncompensated care.

Q So we'll be okay with you if we simply took and netted out the difference between the DSH and the uncompensated care?

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MS. SCHWARTZ: Objection.

A Run that by me again, please.

BY MR. YOUNG:

Q Medicaid is trying to recoup portions of its DSH payments. The hospitals, obviously, are trying to recover uncompensated care too. So you think the two should be netted to the extent there is any additional uncompensated care that they didn't recover from DSH?

A I think DSH is reimbursing them for uncompensated care. And I think, if I understand your question right, that's my opinion.

Q Okay.

A For those years in which they had DSH here that --

Q So for those years, if we simply net the DSH versus the uncompensated care as reported by the hospitals --

A I believe that would more accurately reflect that claim.

Q -- for indigent care, we would be square, in your opinion.

MS. SCHWARTZ: Objection.

BY MR. YOUNG:

Q Is that right? You can answer.

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A That's what I believe is -- more accurately reflects that. I'm not sure I fully understood when you said net amount would be all right with me. Any -- this transfer of disproportionate share would need to be netted against uncompensated care costs, not necessarily uncompensated charges. I want to make myself clear on that.

Q And, then, otherwise you're okay with it?

A I don't see why that shouldn't be offset.

Q But after that calculation is made, you're okay?

A Well, there may be some other things in earlier years where I don't necessarily agree with the uncompensated care or why it should be included in the claim.

Q What year?

A Like uncompensated care is a normal cost of doing business in a hospital. It's no different than bad debts and spoilage and theft in a grocery store.

Q This is just your -- but this is just your opinion about whether or not it should be included, based upon -- you're saying just because it's a general cost -- treating indigents is a general cost

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of doing business?
A Treating indigents is a general cost of doing business.
Q And so you don't think uncompensated care should be included?
MS. SCHWARTZ: Objection.
A Very possibly.
BY MR. YOUNG:
Q Well then, why, then, should Medicaid go after responsible third parties, if treating indigents by the State of Mississippi is just a normal part of doing business?
A Because that reduces the cost to the State. It reduces the -- it reduces the uncompensated care that otherwise would have to be passed along.
Q Well, isn't that true for the hospitals as well?
A They do pursue collections.
Q And isn't that what we're doing here?
MS. SCHWARTZ: Objection.
A What I'm suggesting to you is is this indigent care could have been paid by other people as well, the private pay patient. It's built into the charge structure.

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BY MR. YOUNG:
Q You just don't think your client, the tobacco industry, should pay for it?
A I didn't say that.
Q Okay. Well, are private citizens responsible for this indigent care? Haven't they been footing the bill for this indigent care?
A Sure, they have.
Q Okay. Taxpayers have been footing the bill for this indigent care, haven't they?
A Taxpayers being citizens of the State, yes.
Q Even people that are sick from smoking, indigents that are sick from smoking, taxpayers have been paying the bills, haven't they?
MS. SCHWARTZ: Objection.
A Possibly.
BY MR. YOUNG:
Q What do you mean "possibly"?
A Well, that person could have paid it himself that was in the hospital from smoking-related illnesses. I don't know.
Q If he's indigent, he could?
A He could have been paid under medical -- some other program or he could have paid taxes to

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support the revenue base. I don't know.
Q Do you know if he did pay taxes on those cigarettes?
MS. SCHWARTZ: Objection. Who is "he"?
A I don't know.
BY MR. YOUNG:
Q Other than those two items, the general cost of doing business and netting those, everything else is --
A And the qualifications I gave you as to -- to get a more precise number --
Q The cost to charge ratios?
A Right.
Q Other than that, you're okay?
MS. SCHWARTZ: Objection.
A I can't think of anything at this moment.
BY MR. YOUNG:
Q That would be wrong with it?
A No.
Q I don't want to get surprised by anything, now.
A Well, I said that I can't think of anything at this moment. I --
Q And you've been thinking on this, haven't you?

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MS. SCHWARTZ: Objection.
A I've thought about it.
BY MR. YOUNG:
Q All right. Do you know when each of these hospitals that are reflected in the damage report began to receive DSH payments?
A Based on the documents I saw, I have given you the date of a letter from Medicaid telling them what the transfer would be on their next payment register.
Q Okay. And that Exhibit 7, you've agreed to give me the source documents that you've used in order to make your calculations?
A I believe you were referring to Exhibit 6.
MS. SCHWARTZ: No. For both of them. We did produce for Exhibit 6 and 7. I believe that these documents -- actually I don't know if they are on that list or they were in the stamped production that we gave you. I don't recall right now, but we'll give you the source data for 6 and 7.
MR. YOUNG: We might be done if you will let me take just a break just for a second.
(Off Record)
BY MR. YOUNG:
Q Have you ever been involved in consulting

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for any other type of legal work?
A Not that I recall.
Q No other cases that you can think of in a consulting capacity, not necessarily as a testifying expert?
A Can you give me an example of what you have reference to?
Q For instance, have you ever been consulted to determine how much a business has been damaged or --
A No, no.
Q Never looked at that issue before?
A I've been involved in some determining maybe what some fraud numbers were or something like that, but I don't think that was a -- would fall under the definition of legal issues.
Q Are you going to testify in any way concerning EDS in Mississippi?
A I'll be honest with you, I don't know.
Q You don't know what?
A Whether I will be or not.
MS. SCHWARTZ: EDS, for the record, is also an area we're waiting for document productions as a result of the Helen Wetherbee deposition.
A I have reviewed some documents insofar as

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EDS during the period of time EDS has taken over as fiscal agent.
BY MR. YOUNG:
Q Do you plan to testify as to their adequacy or inadequacies of EDS as a fiscal agent?
A I don't know exactly what that would be.
Q As you sit here today, do you plan to?
A It may be some questions that as to the accuracy of the system since EDS has taken over about, but not specifically about EDS, I don't think.
Q Do you plan to testify as to any other item related to DSH payments that we've not talked about today?
A Not specifically, I don't think.
Q How about generally? We have been down this road before?
A I'm good at generally. There's a program -- Medicare has a DSH program.
Q Medicare is not at issue in this lawsuit.
A I realize that, but the DSH program under Medicare compensates hospitals for providing care to low-income people. That's the only relation that I could be able to think of that may come into play; and whether it does or not, I don't know, quite

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frankly.
Q Any other?
A Issues regarding?
Q DSH payments, provider taxes, anything of that nature?
A Not that I'm aware of.
Q You're not planning on testifying about that?
A Not that I'm aware of today.
Q Intergovernmental transfers?
A We talked about intergovernmental transfers. I think they are transfers.
Q You think what?
A I think they -- what that name says, they will transfer from one governmental agency to another one.
Q Correct. You're not going to -- you don't plan to testify concerning those?
A Not other than to say they are intergovernmental transfers.
MS. SCHWARTZ: Other than ones that he's talked about already today, is that your question?
MR. YOUNG: Yeah.
A Some other type transfers.
BY MR. YOUNG:

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Q Other than the ones you've talked about today, do you plan to make that a part of your testimony, even the ones we talked about today?
A I would think it would have to be -- certainly could be a part of my testimony.
Q In what way?
A That these are funds that were transferred from the hospital to be used by the State for matching funds to ascertain Medicaid monies.
Q But those are separate and apart from the payments -- the DSH payments made to the hospitals?
A Right.
MR. YOUNG: That's it.
MS. SCHWARTZ: I have no questions.
(Deposition Concluded at 4:15 p.m.)

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